

1986-2005:

Conquering a Silent Epidemic



Edited by: Dr. KURIEN THOMAS - Prof. S.P. THYAGARAJAN



1986-2005: Conquering a Silent Epidemic

Edited by:

Dr. KURIEN THOMAS M.D. M.Sc.,

Professor of Medicine, CEU, Christian Medical College & Hospital, Vellore, India.

Prof. S.P. THYAGARAJAN Ph. D., M.D., D.Sc.,

Vice-Chancellor, University of Madras, Chennai, India.

under the auspieces of UNIVERSITY OF MADRAS

AUTHORS



Dr. Bimal Charles

Dr. Bimal Charles has been working for Public Health Issues for the last two decades. He is a medical araduate with Masters in Public Health from London School of Economics. He was working for Christian Medical Association (CMA) of India. He was the Project Director of AIDS Prevention and Control (APAC) project. During his tenure, the APAC project expanded to Pondicherry and Community based strategies for Care & Support activities were introduced. He is currently working for CDC and his firm belief in Primary Health systems has led him to focus on strengthening existing systems, building capacities to respond to emerging needs.

Dr.P.Krishnamurthy, Project Director, APAC VHS has rich experience in Health Administration in planning, implementing, organizing, managing and providing guidance and technical support in health services. While working as Director of Public Health for Government of Tamil Nadu he was involved in programs on primary health care. nutrition, immunization, maternity and child health, family welfare, HIV / AIDS and communicable diseases. He has contributed to many research studies in health sector. He is a member in various health related professional bodies like Tamil Nadu Medical Council, Health Administration, Health Education, etc. The AIDS Prevention and Control Project at VHS, partners with 70 NGOs and encourages public-private partnership in HIV / AIDS prevention to which Dr. P. Krishnamoorthy is the team leader.





Dr.Kurien Thomas

Dr. Kurien Thomas MD. MSc., Professor and Head of department of Medicine unit II at Christian Medical College, Vellore was the Infectious Diseases and HIV coordinator of IndiaCLEN and director of Clinical Epidemiology Unit CMC Vellore. He brings epidemiological focus to important clinical problems of the country. He played a crucial part in the Community prevalence study organised by APAC in 1998 which produced for the 1st time in India data on prevalence of HIV in the community. As a key member of the Indian Clinical Epidemiology Network and as a member of the National Planning Team for NACP III, he has contributed to greater understanding of HIV/AIDS epidemic within the state and at the national level.

Dr Praneeta Varma is in charge of research and intervention among WIP projects of APAC-VHS. She has worked with HIV prevention and AIDS care related issues since 1998. She is responsible for conducting Behavior Surveillance Survey among high-risk populations in Tamil Nadu and Pondicherry, Community prevalence of STI in general population and high-risk populations and evaluations of facilities, campaigns etc. Her grounding in sociology gives her an edge in understanding norms, values and societal approaches that shape-up sensitive interventions among various groups. She has taught sociology at Madras University and has been associated with various national and international agencies as a consultant for different projects on health and development.



Dr Praneeta Varma



Dr.Sudhakar Kurapati is the Senior health professional with extensive experience in the design, planning, implementation and management of national health programs. He has been working on HIV/AIDS issues over the past fifteen years. He was closely associated with the Tamil Nadu program during 1992-1999 as Program Manager of AIDS Prevention and Control project supported by USAID and as a member of the HIV/AIDS Team at the Workd Bank during 1999-2005. He is currently working with COC- New Delhi Office

Dr. Suniti Solomon, since the first detection of HIV in 1986 has been working in this field of HIV/AIDS. She founded YRGCARE in 1993, and continues to be its Director. It is a non-profit organization which offers HIV and sexuality education for adolescents and youth, voluntary counseling and testing services, outpatient and inpatient services for people over 9100 persons living with HIV, Dr. Solomon serves as a scientific member on several national committees. She has published extensively on HIV epidemiology, prevention, care and support, biomedical research, research ethics and gender issues. Her experience cover a wide range of aspects related to HIV infection, from biomedical to socio-economic approaches.



Dr. SUNITI SOLOMON



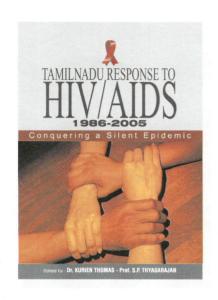
Dr. M. Suresh Kumar

Dr. M. Suresh Kumar, a public health consultant and a psychiatrist, works with injecting drug users. He is a member of the Global Reference Group of WHO for Injecting Drug Use and HIV, a founder member of the global research network on HIV prevention among drug using populations, a director of the International Harm Reduction Association and a research associate of the Centre for Harm Reduction, Burnet Institute, Melbourne. He has worked as a consultant for projects related to injecting drug use in several countries including India, China, Vietnam, Myanmar, Thailand, Malaysia, Sri Lanka, Bangladesh, Mauritius, Kazakhstan and Iran.

Prof. S.P. Thyagarajan, Vice-Chancellor of University of Madras has a creditable career of 37 years in Medical Microbiology in Tamilnadu Medical Services & University of Madras. Having been associated with HIV/AIDS programmes from the very first study of discovery of HIV infection in Tamilnadu, he was incharge of the ICMR/ NACO Centre for Blood-donor screening programme at Dr. ALM PG IBMS and carried out several projects in HIV / AIDS including the 12 years long Indo-UK (HEL) project on HIV/AIDS and the USAID project on community prevalence of STD & HIV in Tamilnadu. He has published 316 research papers & is credited with 19 international & national awards in Medical Microbiology and Infectious Diseases. His areas of specialization are Viral Hepatitis, HIV / AIDS and development of drugs from Indian Medical plants.



Prof. S.P. Thyagarajan



Tamilnadu's Response to HIV/AIDS Epidemic

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ocumenting "Tamilnadu response to HIV/AIDS" in its strength and weakness was a cherished dream for many of us who have been involved with the epidemic response in the state. It has been a privilege for University of Madras to become the focal point of this effort. Success of this project is largely because of the unstinted guidance and collaboration of governmental and non-governmental organizations, stalwart medical, scientific and political experts.

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List of Abbreviation

AIDS	Acquired improved deficiency Quality		
	Acquired immunodeficiency Syndrome	INDIACLEN	Indian Clinical Epidemiology Network
ART	Anti-retroviral Therapy	IVDU	Intravenous Drug Users
ARV	Anti-retroviral Drugs	MCH	Maternal and Child Health
ANC	Antenatal Clinic	MSM	Men having sex with men
ANM	Auxiliary nurses and midwives	NACO	National AIDS Control Organization
APAC	AIDS Prevention and Control	NACP	National AIDS Control Project
APP	Allopathic Private Practitioners	NFHS	National Family Health survey
BCC	Behavior Change Communication	NGO	Non Governmental Organization
BED- EIA	BED-Enzyme Immuno Assay	PATH	Prevention Along the Highway
BSS	Behavioral Surveillance Surveys	PCI	Project Concern International India
BSC	Blood Storage Centres	PLHA	People Living with HIV/AIDS
CAPAS	Chennai Corporation AIDS Prevention and Control Society	PRAMS	Physicians Responsible for AIDS Management
CAB	Community Advisory Board	PSI	Population Services International, India
CAN	Community Action Network	PPTCT	Prevention of Parent-to-child
CBOs	Community Based Organisations		Transmission
CDC	Center for Disease Control	PWDS	Palmyrah Workers Development Society
CETC	Continuing Education and Training Centers	PWN+	Positive Women Network
CHES	Community Health Education Society	RIMP	Registered Indigenous
CHW	Community Health Workers		Medical Practitioners
CMCH	Christian Medical College and Hospital	SACS	State AIDS Control Society
CSW	Commercial Sex Workers	SAEP	School AIDS Education Programme
DAAC	District AIDS Advisory Committee	SHG	Self-Help Group
DRDA	District Rural Development Agency	SIAAP	South India AIDS Action Program
ELISA	Enzyme Linked Immunosorbent Assay	SIP+	South Indian Positive Network
FCSW	Female Commercial Sex Workers	TANSAC	Tamil Nadu State AIDS Control Society
FHI	Family Health International	TN	Tamil Nadu
FHAC	Family Health Awareness Campaign	TNVHA	Tamil Nadu Voluntary Health Association
GHTM	Government Hospital for Thoracic Medicine	TNP +	Tamil Nadu Network of Positive People
GFATM	Global Funds for AIDS,	UNDP	United Nations Development Programme
	Tuberculosis and Malaria	UNICEF	United Nations Children's
GOI	Government of India		Education Fund
HAART	Highly Active Antiretroviral Therapy	UNAIDS	United Nations Programme on HIV/AIDS
HBV	Hepatitis B Virus	USAID	United States Agency for
HCP	Health Care Providers		International Development
HIV	Human Immunodeficiency Virus	VCCTC	Voluntary Confidential Counseling and Testing Center
HICC	Hospital Infection Control Committee	VCTC	
HPPWS	HIV Positive People Welfare Society	VCTC	Voluntary Counseling and Testing Center
ICMR	Indian Council of Medical Research	VHS	Voluntary Health Services
IEC	Information, Education & Communication	YRG CARE	Y.R.Gaitonde Centre for
IRB	Institutional Review Board		AIDS Research and Education
IDUs	Injecting Drug users	WHO	World Health Organization
INCLEN	International Clinical Epidemiology Network	WIP	Women in Prostitution

V.K. Subburaj, IAS, Secretary to Government



Health & Family Welfare Department, Fort St. George,

Chennai - 600 009. Phone: 044 - 2567 1875

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FOREWORD

Epidemiology and Surveillance are the integral components of disease burden assessment, prevention & control programmes in general and HIV / AIDS in particular. Chronological documentation of these programmes largely help in the execution of public health measures and to conduct research for planning the future disease control/eradication programmes.

The Government of Tamil Nadu has pro-actively planned and implemented innovative methodologies to prevent and control the onslaught of this dreadly HIV infection. This epidemic is now in downward trend in this State. The Government has been fully committed from the very beginning to take leadership role in HIV / AIDS control to the entire country. Tamil Nadu is the first State in India to establish a Tamil Nadu State AIDS Control Society (TANSACS) to take care of entire spectrum of HIV / AIDS control, care and treatment related activities in the State. Today this Society model has been emulated by many other States in India as recommended by NACO.

It is appropriate to look back and document by multidimensional approaches as to how Tamil Nadu has handled this silent epidemic of HIV / AIDS over the last 20 years, the lessons Tamil Nadu has learnt and the leads the State has provided to other States of the country in managing this stigmatized disease.

I appreciate Prof. S.P.Thiagarajan, Vice-Chancellor of the University of Madras, who along with Dr.Kurien Thomas from CMC Hospital, has successfully brought out this significant pilot documentation on "Tamil Nadu Response to HIV / AIDS, 1986-2005" with contributions from TANSACS, APAC, Government Thoracic Medicine Hospital, Tambaram, YRG CARE and other non-governmental agencies, Stalwart Medical & Scientific Experts.

I am confident that this documentation book would be a source of factual informations, chronological data on the development sequence of HIV / AIDS program of Tamil Nadu and also a ready-reckoner for reference and guidance for all those who are involved in HIV / AIDS programs in Tamil Nadu and in other States of India. I compliment the University of Madras for having co-ordinated this valuable project and INCLEN / USAIDS for the financial assistance granted to this venture.

My hearty appreciations to all the contributors of this documentation.

(V.K. SUBBURAJ)

Prelude

ver since the first report of the entry of HIV into the country, the State of Tamil Nadu has faced the challenge with poise, responding positively to the epidemic as evidenced by fact that TN is the first state in India where its classification as a high prevalence state (> 1%) has dropped to medium prevalence since the initiation of the National AIDS Control Program (NACO).

This achievement by the state can be credited to the multifaceted involvement of the government, non-governmental organizations, academia, and by the civil society. The resilience to fight the epidemic was strong among all the sections of the community. Tamil Nadu initiated the formation of the Society model targeted towards the control of AIDS, an organization now called Tamil Nadu State AIDS Control Society (TANSACS). The state saw the development of community-based health care system. Organized attempts were made to create awareness among the general population and target groups. People living with HIV were involved in policy making. Thus the state has shown how strong commitment and leadership, proper implementation of ideas and appropriate utilization of resources can result in decrease of the spread of HIV/AIDS. Though Tamil Nadu has savoured success, challenges are still daunting. There are many PLHA who are still deprived of the care and support they need. The epidemic has now afflicted every section of the society especially the housewives and is making in-roads into many more sections like the IDUs, MSMs, etc.. The challenge faced now is not to let go of the achievements. The task ahead is to continue to bring down the spread of HIV and to provide an enabling and empowering environment for those already infected.

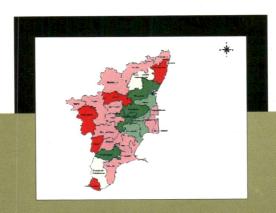
This is a documentation providing an insight into what happened in Tamil Nadu from 1986 to 2005 and what more could be done in the future to achieve the target of bringing HIV/AIDS under control.. A review has been made of the different stages of the epidemic, the care and support that were available to PLHA and the efforts taken by the political, administrative and the community towards the prevention and control of HIV/AIDS. The document reports the response and the sequential development of the different organizations to fight the disease in the state.

The documentation of the information will be a record of the major efforts undertaken to reach this situation. The report could be used as a guide for policy-making in this State as well as, as a model for the other states of the country. The report reinstates the importance of knowledge, leadership, awareness, channeling of resources and commitment in the control of a disease as grave as HIV/AIDS.

S.P. THYAGARAJAN

Epidemiology of HIV/AIDS in TAMILNADU

Dr. Kurien Thomas - Dr. Suresh Kumar



From the time of first report of HIV positive cases in Tamil Nadu in 1986¹, the state has generated valid and important information on the epidemiology of HIV/AIDS in Tamil Nadu which has influenced the development of the AIDS control program in other states and at the National level.

The First Report from India

Simoes EAF, Babu PG, John TJ, Nirmala s, Solomon s, Laksminarayana cs and Quinn TC

r. Eric Simoes was working with Dr. T.Jacob John in department of virology at Christian Medical College Vellore when HTLV III was discovered in 1984. Eric wanted to search for the virus in India. Preliminary exploration of interest in the institution was not very encouraging since many of his colleagues believed that homosexuality was prerequisite for HIV infection and this was uncommon in India. Eric persisted and succeeded in getting a short term training at NIH with Dr. John Sever in USA for performing the ELISA test for HTLV III. On return from USA he tested individuals with renal failure with history of multiple

blood transfusions and dialysis for evidence of infection but was noted to be negative. The next alternative considered was to test the blood of commercial sex workers (CSW) in the port city of Chennai which could be a natural entry point for the virus.

Dr. Nirmala S was working with Dr. Suniti Solomon

in Chennai for her M.D. thesis and had collected blood samples from a group of sex workers from a remand home but did not have the kits to perform HIV tests. While they met Dr. T.Jacob John at the Post Graduate Institute of Basic Medical Sciences, University of Madras in a Hepatitis Workshop organized by Dr. S.P. Thyagarajan, in January 1986. The situation offered an excellent opportunity for collaboration. Facilitated by the then DME, Dr. Lalitha Kameswaran, the samples collected from Chennai were sent initially to Christian Medical College, Vellore where 6 were reported positive for HIV antibodies.



Collaborative effort-lead to discovery of HIV entry.

The samples were then sent to NIH, USA through ICMR for reconfirmation. The positive results were reported to Director General of Indian Council of Medical Research. Understanding the significance of this report, **Dr. Ramalingaswamy** (DG-ICMR) informed the results to Mr.Rajiv Gandhi, the then Prime Minister of India and to Dr. Hande, the Minister of Health in Tamilnadu. Dr. Hande announced this to the Tamilnadu assembly the very next day. This report on the presence of HIV infection in high risk groups in the state initiated the multifaceted response in the country.

Blood samples of 412 women were subsequently screened in 1986 from 6 remand homes from across the different cities in the State in Tamilnadu (TN) and 14 of these were reported positive. With the discovery of the virus and the first case report from India, the first instance of stigma and discrimination also emerged. The names of the sex workers who were tested positive became public through news paper reports. Many of these unfortunate individuals had to suffer discrimination and rejection by the society and family.

Would we have done this any differently to-day?

Progress of the Epidemic from 1986 to 2004

The progress of the epidemic in TN could be described in three phases.

- The early phase (1986-1991) when the spread occurred from high risk groups in Chennai to bridge population and high-risk groups in other parts of the state.
- The consolidation phase (1992-1998) when the spread occurred from high risk group to general population.
- The stabilization Phase (1999-2004) Stabilization and early signs of decreasing trends in HIV prevalence.

Early Phase:

The first published report of HIV from 6 remand homes in the state showed an overall prevalence of 3.4% among CSWs in the state in 1986 [2.3] (Table-1) The higher levels of HIV prevalence among the CSWs in Chennai as compared to other cities /towns of the state suggested that Chennai was probably the portal of entry of HIV to the state of TN.

Table 1: Sero-Prevalence of HIV in CSWs in Tamilnadu 1986 3

City / Town	No Tested	HIV +ve			
	-	No	Percent		
Chennai	102	10	9.8		
Madurai	91	3	3.3		
Coimbatore	52	0	0		
Tiruchirapalli	98	0	0		
Vellore	57	1	1.8		
Salem	12	0	0		
Total	412	14	3.4		

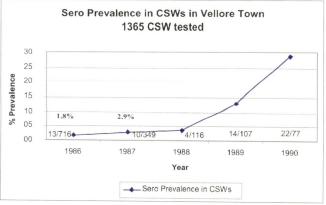
During the early phase from 1986 to 1991 HIV was largely limited to CSW, and their clients (measured in sexually transmitted diseases (STD) clinic attendees). In Vellore town, systematic screening of blood donors found 10/6136 positive (0.16%) [4]. By 1987 there was already evidence of bridge population being involved in the spread of the epidemic. Over a 2-

year period, HIV had made inroads into other high risk groups and populations. In Vellore town 2 of 1237 STD clinic attendees were detected to be positive ². The HIV epidemic also spread

rapidly among the CSWs, in the state. Follow up report by Simoes from 1986 to 1990 of newly admitted CSWs, from Vellore showed that prevalence increased from 3.4% to 28.6% over a 5 year period ^[3] (Fig.1)

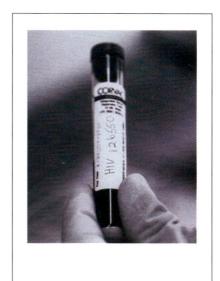
Two prospective systematic investigations of new patients with STDs at STD clinic of CMC Hospital carried out in 1990 and 1995 [5.6]. In the first report by Mathai. et al, among 2215 subjects, 9 were positive for HIV

Figure 1: HIV Sero-prevalence in CSWs Vellore Town



giving a rate 0.04%. The second report by Jacob et al of 5883 subjects showed a prevalence of 1.79%.

This evidence of spread of HIV to the large metropolis cities of Chennai, Madurai, Thiruchirapalli, Salem and Vellore helped to bring attention on the HIV epidemic at the National level. In 1989 the Indian Council of Medical Research (ICMR) established 30 screening centers in various states in India and showed that HIV had penetrated into many states of India. These findings contributed to providing evidence for the policy makers who responded effectively by the formation of the State AIDS Cell which was later transformed into Tamil Nadu State AIDS Control Society (TANSACS). This state level society model for HIV/AIDS prevention and control was later adopted by the national program and became an important component of the National AIDS Control Plan, Phase II.



Phase II Consolidation of HIV epidemic-Progression of Disease in TN:



Data from sentinel sites demonstrated the spread of HIV into the general population. Routine sentinel surveillance for HIV in Tamilnadu was initiated by Dr.Suniti Solomon in 1989 in department of Microbiology at Government General Hospital/Madras Medical College, Chennai. Early sentinel surveillance reports from 1989 to 1993 from STD clinics, antenatal clinics and voluntary blood donors attending government hospitals showed an increased incidence of HIV in all 3 groups under surveillance in Chennai [7].

By 1992, increasingly people living with HIV started to signs of opportunistic infection, especially tuberculosis (TB). At the Institute of Thoracic medicine at Chennai, Anuradha et al ^[8]. reported that ELISA and Western Blot were positive in 3 of 760 blood specimens collected on 38 consecutive Tuesdays. All of these patients were noted to have pulmonary TB. The

prevalence was calculated to be 0.39% overall for respiratory diseases and 0.77% for pulmonary TB. The trend of TB HIV co-infection in Tamilnadu has continued to increase with HIV prevalence rising to 3.5% by 1995.

Among patients with AIDS seen in the Christian Medical College Hospital (CMCH), three publications^[9,10,11] in 1992, 1995, 1997 reported that the most common clinical presentation of AIDS was tuberculosis both pulmonary and extra-pulmonary. These reports from Vellore described the clinical profile of first 19 patients in 1992 ^[9], 61 patients from 1986-1992 ^[10] and 187 men and 24 women (M:F=8:1)from April 1987 till December 1994 ^[11]. The doubling time of the occurrence of AIDS cases was observed to be 14 months; during 1987-90 there was an average of 5.7 cases per year; in 1991-93 there were 28 per year; in 1994 there were 104 cases. The mean age of patients was 33 years for men and 31 years for women. Among men, the primary mode of infection was heterosexual

contact with female commercial sex workers. Among women, the most common source of infection was their husbands. There were 135 patients from urban and 76 from rural communities suggesting rural spread of the disease as well. It is evident from these reports that it would be difficult to differentiate AIDS from other cases of TB and malnutrition in India. Common symptoms of significant weight loss, prolonged fever, chronic diarrhea were difficult to distinguish from Non HIV/TB and malnutrition. On follow up as per the 1995 report, 33/61 (54%) patients had died during a mean period 07/4.5 months from the time of their diagnosis [10].

Between 1992 and 1998 HIV prevalence among blood donors increased from 1.5 per 1000 in 1988-1989 to 3.1 in 1992-1993. The prevalence rate in 1992-93 (3/1000) was significantly higher than that of the previous years (P<0.01).

During the second phase TANSACS and AIDS Prevention and Control Project (APAC) of the Voluntary Health Services (VHS) provided strong leadership in developing effective interventional strategies and setup systems to monitor the status of the epidemic in the state.

Tamilnadu State AIDS cell which initiated sentinel surveillance in the STD clinic at the department of microbiology, at Government General Hospital was later expanded to Coimbatore. Subsequently it was scaled-up by TANSACS over the next few years to obtain information on HIV sero-prevalence from 69 antenatal clinics, 11 STD clinics and other high risk groups.

Over time the number and type of surveillance sites were increased and made more representative. The methodology adopted for sentinel sites followed NACO guidelines for sampling and selection of subjects. Up until 1998, there were only 3 sentinel sites reporting from STD clinics and there were no CSWs, MSM or IDU sites in the program. There was insufficient capacity for analysis and reporting was also weak. However, by strengthening linkages with partners the capacity of TANSACS was improved and the sentinel surveillance report published by TANSACS in 2003 is a good example of collaborative efforts of NACO, TANSACS, NIE, APAC and other partners [13]

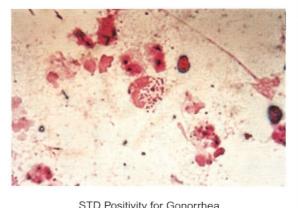
A major weakness of information generated in the sentinel surveys was that the sites were largely located in the urban regions of the state even though other data sources suggested that the HIV epidemic had spread to rural areas. And, there was very little information on the burden of sexually transmitted diseases (STD) in the general community. Therefore, the APAC, developed a consortium of partners in 1998 to obtain information on the prevalence of STD and HIV at the community level. The project was supported by USAID through APAC and International Clinical Epidemiology Network (INCLEN).

Community Prevalence Study, 1998

In the study [14], 1981 individuals (1157 women & 824 men) were selected and screened for STDs and HIV from 1114 households representing 25 million projected adult population of Tamil Nadu. The study showed that HIV had spread to rural regions of Tamilnadu and was no longer localized in the urban areas. Though the conclusions about rural spread of the disease were controversial at that time, APAC initiated activity in the rural regions of the state also. Subsequent follow up studies have demonstrated rural spread of HIV in many parts of India.



Community Prevalence Study for STD/HIV by health camp approach (1998)



STD Positivity for Gonorrhea

Table 2: Community Prevalence Study -1998 [STD Study Group, 2002]

	ALL	Loc	ation		Sex	Age Group				
STD		Rural	Urban	Male	Female	15-19	20-29	30-39	40-45	
Any STD	14.6	14.8	14.0	12.6	16.0	14.4	14.1	15.1	14.4	
Classical STD	8.3	7.6	10.2	5.6	10.1	4.8	9.2	8.2	8.2	
Gonorrhoea	3.8	3.5	4.4	3.5	3.9	2.3	4.4	3.7	3.5	
Syphilis	0.3	0.2	0.5	0.3	0.3	0.4	0.08	0.01	1.1	
Chlamydia	1.3	1.0	2.1	1.1	1.4	-	1.6	1.4	1.0	
Trichomoniasis	5.2	5.3	5.0	_	5.2	0.25	4.4	6.4	6.0	
HBV	5.3	6.0	3.3	6.0	4.8	10.4	4.0	5.7	4.8	
HIV	1.8	2.2	0.8	1.5	2.1	_	1.9	1.8	2.3	
HSV2	1.2	1.0	1.8	1.0	1.4	2.3	1.6	1.3	0.4	

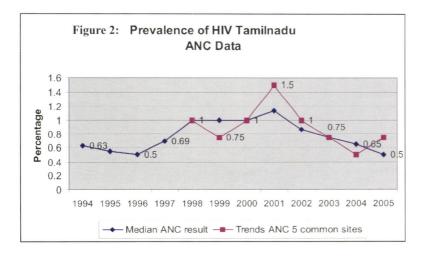
There was increasing epidemic spread from high risk population to general population over the next few years in Tamilnadu even as most other states in India reported cases of HIV. By 1998 the antenatal surveillance showed 1.25% sero-prevalence of HIV and Tamil Nadu was described as one of the high prevalence states in India along with, Maharashtra and Manipur.

Phase III Stabilization of the Epidemic

The third phase of the HIV epidemic in Tamilnadu, from 1999 to 2004, is when the concerted efforts and multifaceted responses by Government, Non Governmental Organizations (NGOs), Academia, and Civil Society to control the epidemic started to show dividend. Leadership for this came from within and outside the state and successful collaborations were developed for prevention, surveillance, care and treatment activities. Based on the results of the 2005 surveillance data Tamilnadu was reclassified as a moderate prevalence state [15]. HIV prevalence in Antenatal Clinic (ANC) has been noted to be 0.5 and 0.75 in 2004 and 2005 respectively in 5 common centers performing surveillance from 1998 to 2005.

Results of sentinel surveillance:

Results of the ANC sentinel surveillance [15] from 1994 to 2005 show that there is declining trend in prevalence from 2001 onwards with the current level between 0.5% and 0.75% as shown in the graph below:.



High Prevalent districts of Tamilnadu

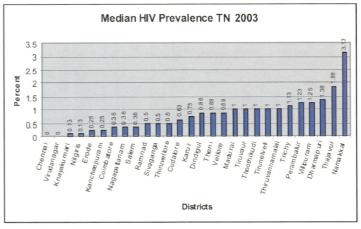
Even though the overall state prevalence at ANC sites has shown a down trend since 2001, the district level data shows that there are many sub-epidemics in the state with some districts showing a continued

continuing challenge to the State.

increase in the HIV prevalence. Controlling the HIV epidemic in these areas represents a

Sentinel surveillance [13] revealed 8 high prevalence districts in the state in 2003. Median HIV prevalence in antenatal sites in Namakkal, Thanjavur, Dharmapuri, Perambatur, Villipuram and Trichy also remained over 1% in 2003. The prevalence in some STD clinic attendees also show an uptrend in Madurai in consecutive years (10.4 to 16.8 to 15.6 to 24.8 to

Figure 3: Median HIV Prevalence In Different Districts Of Tamil Nadu- 2003

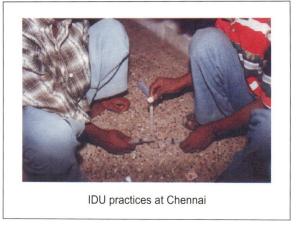


20.8), Thanjavur (9.6 to 11.2 to 14.4), Tirunelveili (22% to 34%) and Vellore. (1 to 6%).

HIV in Injecting Drug Users (IDUs)

Controlling HIV among injecting drug users remains one of the important challenges in the State. Injecting drug use is not uniformly distributed and it is prevalent in some parts of the city of Chennai; it is also reported from other towns of Tamilnadu, notably, Madurai and Tuticorin. Majority of drug users in Chennai are males, marginalized, poor, engaged in casual work (loading, transportation, carting) and live in unhygienic settings. Although heroin is available since 1983 in Chennai, the mode of administration shifted from 'chasing' to 'injecting' in the 1990s. Injecting drug use is now well established in Chennai among the opioid users and primarily, there are two kinds of injectors heroin injectors and buprenorphine injectors. [16]

Though prevalence estimates among IDUs have been carried out among convenience samples from treatment centers in Chennai from 1996, the sentinel surveillance data for IDUs is available from the year 2000. Since that time, however, HIV prevalence of over 20% among IDUs has been consistently observed with a current prevalence rate of 33.2% in 2005. The sudden jump in HIV prevalence among IDUs during the year 2003 to 63.8% is attributed to change of site recruited for sentinel surveillance. A recent research [17] has identified the following



risk factors for HIV infection among IDUs: living in northern part of the city; injecting in drug selling places; 'tattooing'; and, history of incarceration. The same study found an overall prevalence of 5% HIV infection among the regular sex partners of the IDUs; and, sixteen percent of the regular sex partners of HIV positive injecting drug users were found to be HIV infected.

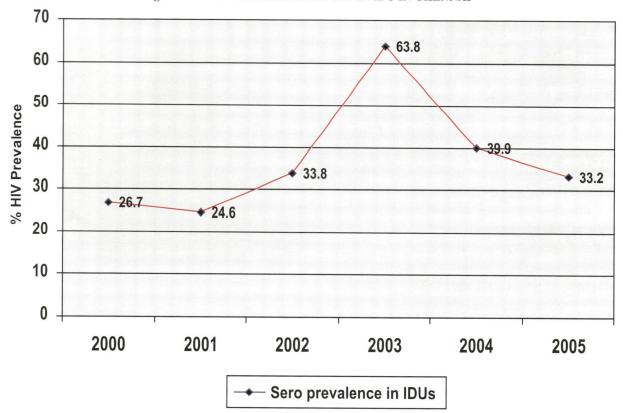
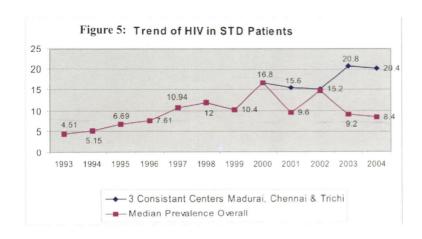


Figure 4: SERO PREVALENCE OF HIV IN IDU IN CHENNAI

HIV in STD Clinic Attendees:

The number of STD sentinel sites have increased from 2 in 1993 to 11 in 2005. There does not seem to be a definite reduction in p evalence of HIV in STD patients till 2004. It is of concern that in some districts in TN the HIV prevalence have gone up in STD clinic patients 2002 to 2004 (Trichy 15.2% to 20.4%, Thanjavoor 11.2% to 14.8%, Thirunelveli 22.0% to 14.0%).



New HIV infections in STD Clinic:

Changing pattern of HIV infection is best studied by evaluating new infections and assessing the 'incidence'. Detuned HIV-1 assay (BED-Capture EIA) was performed in 42 HIV positive patients who attend the ambulatory STD

care center at Chennai ^[18]. New infection was noted to be 7 /42 by BED capture EIA. Anualized HIV incidence in this population was noted to be 3.3 per 100 person years (CI: 0.8-5.7%). Follow up studies are needed to show changing pattern of new infections.

Prevalence in Commercial Sex Workers:

Systematic information from CSWs in Tamilnadu is scanty. The early reports from Vellore³, showed an increase from 2.9% to 28.6%. In 2003 the first 1 CSW sentinel sites were added in the HIV surveillance of high risk groups. In 2003, 9.5% (CI:6.1 12.8). of 293 CSW recruited during a community prevalence study by APAC. were found to be HIV infected here rates are lower than reported in CSW in the neighboring states and may reflect the success of the ongoing intervention programs among high risk groups.

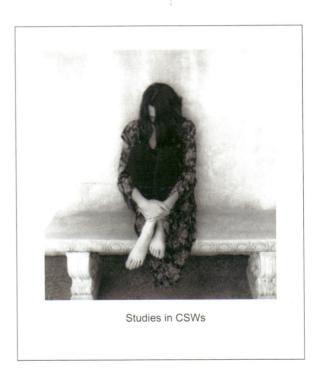


Table 3: COMPARATIVE DATA ON CSW PREVALENCE IN INDIA

	1987 (TJJ Vellore)	1990 (TJJ Vellore)	2003 (TANSACS Sentinel data)	2003 (APAC CSW)	2000 & 2001 Andra Pradesh and Surat
STD Prevalence in CSW	venore)	venorey		56%	
HIV Prevalence in CSW	2.9%	28.6%	8.8%	9.5%	30-40%

Prevalence among Truckers and Helpers in TN:

Truckers and helpers are not included in the national sentinel surveillance survey and so there is little information about the extent of HIV those groups. The AIDS Prevention and Control Project undertook a survey [20] of STI and HIV among Truckers and Helpers in 2003. Among truckers and helpers in the 10 APAC intervention sites, 15% had a laboratory confirmed STI and 4.1% were HIV infected. These data point to the continuing need for interventions among this important bridge population in Tamilnadu.



Inter Versions for Highway Truckers

Prevalence in MSM Group

Information about the prevalence of HIV among MSM Tamilnadu has only become available since 2000 when the first sentinel site was established in Chennai. Subsequently a second site was established in Villupuram. In 2003, 2004, 2005 HIV prevalence in this group was found to be 4.4%, 6.8% and 6.2% respectively [15] (Sentinel Surveillance 2005). Though limited, these data support the need for continuing to develop and support HIV prevention and care programs for MSM in Tamilnadu.



Community Prevalence 2002 and 2003:

Tamilnadu is unique in that the state has made attempts to validate assumptions in sentinel surveillance data by community prevalence studies on STD and HIV. Three surveys, including 2 by APAC (1998 and 2003) and one by TANSACS/NACO (2002) have been carried out. The community studies also provided information on the burden of disease caused by common sexually transmitted diseases (STD), other related conditions and clinical

syndromes affecting the general population in Tamilnadu.

The community prevalence survey conducted by NACO ^[21] in 2002, in 2 urban and 7 rural sites detected STD prevalence of 8 common STD conditions to be 29.6% and HIV prevalence was noted to be 0.94%. The community prevalence survey conducted by APAC ^[22] in supported the downward trend observed in sentinel surveillance, estimating HIV prevalence to be 0.7% with no difference between urban and rural areas. The data is given in the table below:

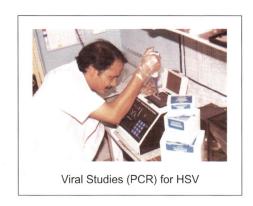


Table 4: APAC COMMUNITY SURVEILLANCE STUDY - 2003

Type of STI	Total	No +ve	Prevalence	Location %		Sex in %		Age group in Years %			
	No Tested			Rural	Urban	М	F	15-19*	20-29	30-39	40-49
Syphilis [TPHA+RPR]	1342	15	1.1	1.4	0.8	1.0	1.2	-	1.0	1.0	2.0*
Gonorrhea [Culture]	1254	18	1.4	0.7	2.3	2.3	0.7	6.0	1.0	1.0	3.0
Chlamydia [PCR]	366	1	0.3	-	0.6	-	0.3	-	-	1.0	-
Trichomoniosis [Wet mount]	705	39	5.5	6.0	5.1	-	5.5	8.0	4.0	6.0	7.0
HIV [ELISA]	1318	10	0.7	0.6	1.0	1.4*	0.3	-	1.2*	0.8	-
HBV [ELISA HBsAg]	1340	37	2.8	2.2	3.5	3.9	1.9	2.0	3.0	2.0	5.0
HSV2 [ELISA IgM]	1326	27	2.0	2.3	1.7	1.0	2.8*	-	2.0	2.0	2.0

*p value < 0.05

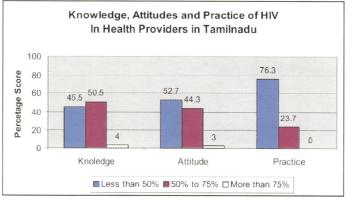
Viral Epidemiology in TN

The Tamilnadu epidemic is predominatly caused by HIV Type -1 (Subtype-C). The first report of HIV-2 type was noted from a set of 604 sera where one was positive for combined infection. In another set of 24 samples from Vellore [23] with indeterminate blot profiles, one was positive for HIV2. In a study on prevalence of HIV-1 and HIV-2 in selected urban and rural centers in Tamilnadu. Suniti Solomon et al showed that HIV-2 forms only 4-11% of all HIV infections in the state [24].

Anti-retroviral therapy (ART) have made a significant impact on the prognosis of HIV/AIDS patients globally. The pattern of drug resistance in 50 treatment naïve subjects with HIV-Subtype C were studied in the state [25]. The report shows that major protease inhibitor resistance was noted in 20% of subjects while mutations in the inhibitor positions of Nucleoside reverse transcriptase (NRT) and Non-nucleoside reverse transcriptase (NNRT) was noted in 6% and 14% respectively. The importance of this information on clinical outcome of subjects is not clear at the moment but requires further evaluation and follow up of patients on cohort of patients on treatment.

The first documented report [26] in a health care provider from Tamilnadu was recorded in 1999. Although the experience Tamilnadu has shown that the risk of transmission of HIV to health care professionals is very low. Fear of HIV infection continues to result in stigma and discrimination against People living with HIV/AIDS (PLHA) and in many instances mandatory/routine HIV

Figure 6 : Knowledge Attitude and Practices of Health Care Providers



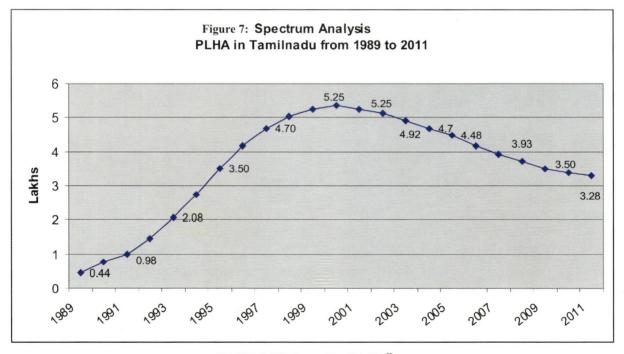
testing of patients accessing health care. Knowledge, attitude and practices of testing HIV by health care professionals (public and Private sector) were evaluated by IndiaCLENgroup in 2003 and show that most health providers have inadequate knowledge and poor attitudes to HIV in the state. In addition, few practiced quality HIV testing [27]. There is a critical to education of health care providers so as to reduce the stigma and discrimination in care and support activities in the state.

Future Projections of the Epidemic in Tamilnadu

"Prediction is very difficult, especially if it's about the future." Nils Bohr, Nobel laureate in Physics

It is also true to remember what Henri Poincare pointed out in The Foundations of Science "It is far better to foresee, even without certainty, than not to foresee at all." As India emerges into the 3rd phase of the national program on HIV/AIDS (NACP-III), there is need to re-evaluate the projections for the future of the epidemic in India to plan and monitor interventions for 2006-2011. Under the leadership of NACO and the surveillance working group estimations and projections for Tamilnadu have been carried out. The models used assumed the sentinel surveillance was valid and that the current levels of interventions will continue in the state.

Dr.DCS Reddy et al [28] have estimated that there were nearly 4.7 lakhs of people living with HIV/AIDS in Tamilnadu at the end of 2004. At the current level of interventions, it is projected by spectrum analysis that the numbers will decrease to 3.3 lakhs PLHA by 2011. NACP III is expecting to expand condom coverage and to scale-up ART with linkage to prevention. With these added intervention, it is possible that there will be an even greater control of the epidemic in TN over time.



NACP III PIP Appendix- NACO 28

Summary

The early research and publication of results generated by academic, ICMR institutions and Other organizations like Christian Medical College Vellore, Madras Medical College at Chennai, Tuberculosis Research Center, YRG Care, APAC, TANSACS and University of Madras provided the rationale for Government and other stake holders to mount an effective response in the state to control the HIV/AIDS epidemic.

TANSACS and APAC through partnership with individuals, NGOs and Civil Society established interventional responses and set up systems to generate information on the progress of the epidemic in the state. The number of partnerships has increased in recent years and with leadership from TANSACS continue to generate data that will be useful in guiding the state response.

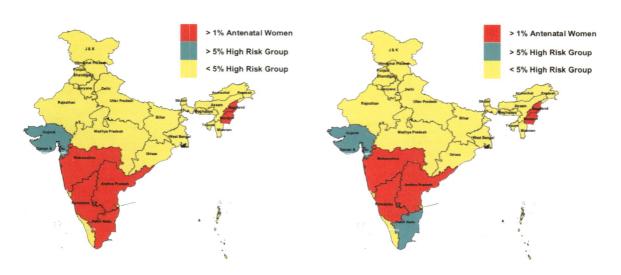
Comparison of data from community prevalence studies and hospital prevalence studies undertaken by APAC and other stake holders in the state have substantiated the downward trend shown in the general community. However there is need for mortality and incidence data to interpret the trends more effectively.

Although the results are encouraging, areas of high prevalence remains a concern. HIV Prevalence in Female Commercial Sex Workers (FCSW) is still at unacceptable 10% level. In some districts prevalence of HIV in the bridge population of STD clinics also is increasing. Lack of effective coverage of IDU and MSM groups in the state with drug substitution and needle exchange program remains an important challenge for the state.

Transition from High prevalence to medium prevalence

Prevalance Levels 2002

Prevalence Levels 2005



TN is the only state in India where there is a clear shift from high prevalence state (> 1%-red) to medium prevalence (< 1% -green) since the initiation of the NACP. But there is no reason for complacency and the analysis clearly defines the need to focus on the areas of weakness particularly targeting MSM and IDUs.

Knowledge accrued through authenticated documentation is beginning of Success in controlling emerging epidemics

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Care, Support and Treatment program 1986-2005

Dr. Suniti Solomon, and Rochelle D'Souza Yepthomi

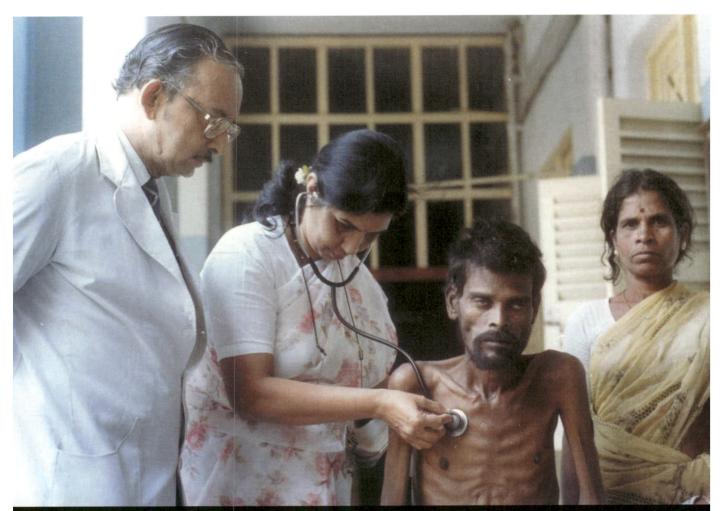
N has a unique place in the care and support of people living with HIV/AIDS in India. Though there is documentation^{1,2} on the response of TN to the epidemic, there are many NGOs, Community Based Organisations (CBOs) and individuals who have made significant contributions yet have not been able to record their works and increase their visibility. The present document tries to



reflect the major contribution of the government and NGOs in the state in the area of care, support and treatment (CST). It is not an exhaustive report in itself and hopes to encourage others to realize the importance of documentation for sharing lessons learned.

Care and support

The sharp increase in the number of HIV infections in Tamil Nadu made it imperative that the state provide clinical care and services to improve the social and economic well being of the people living with HIV/AIDS in addition to its focus on awareness generation. CST activities include clinical care particularly treatment of opportunistic infections, psychosocial support, building non discriminatory attitudes towards people at workplaces and educational institutes and definitive treatment through provision of ART. CST also includes attention to the needs of women living with the infection, having complete choice in making decisions regarding pregnancy and childbirth so that they can make appropriate informed decisions without coercion in one way or the other including prophylactic treatment for prevention of mother to child transmission.



FIRST AIDS CASE DIAGNOSED AT GOVT. GENERAL HOSPITAL, CHENNAI.

Care in the early days:

It soon became apparent that sentinel surveillance was not sufficient to contain the spread of HIV infections and behavioural risks. Pre test and post test counseling sessions accompanied HIV testing at the AIDS cell of the Madras Medical College. The AIDS Resource Group was formed to overcome the denial of health care personnel of the actual existence of the HIV infection in the

state and address the challenge in providing clinical care to those in need. Training and advocacy programs for clinicians were initiated to reduce the stigma and discrimination associated with the disease.

The first ward for admitting patients with HIV was started at the Government General Hospital in 1992 with the involvement of Dr Suniti Solomon and Dr Jayakar Paul and later by Dr CN Deivanayagam. The specialty ward had 20 beds; 10 beds each for male and female patients. Mr K Inbasagaran was then the Health Secretary and contributed much to the initiation of



First HIV/AIDS workshop for Doctors at Govt. General Hospital, Chennai. Sponsored by British Council in 1986

this program within the governmental setting and in meeting with the HIV stigma and in developing positive attitudes towards people living with HIV.

The Tamil Nadu State AIDS Project Cell (TANSACS) has been a forerunner in the greater involvement of people living with HIV at all levels. It has been a support to the growing positive group networks since 1996 with Indian Network for People living with HIV/AIDS (INP+), Tamilnadu Network of Positive People (TNP+) and Positive Women Network (PWN+) in its formative stages. TANSACS has also allotted representation of a positive person in the Executive Committee [EC] as an ex-officio member; thus ensuring visibility and inclusion of concerns and view of PLHA in the decision making process. It now has a policy of funding NGOs only if they have at least one positive person on its employment rolls.

Early Phase (1986-1991)

Through a unique programme, TANSACS has trained a number of Physicians Responsible for AIDS Management (PRAMS). These physicians are based in Medical Colleges and District Hospitals across the State and are trained in the management of AIDS patients. Opportunistic infections are treated and chemoprophylaxis started if the CD4 is below 200.

Besides public health system in Chennai, other public health centers in TN also took up the challenge of providing care and support to its people living with HIV. At Namakaal, the Government hospital provides VCT and intervention protocols (along with the MGR University) for the prevention of mother to child transmission (MTCT) of HIV. The TANSACS has sanctioned 10 beds in various community based NGOs run by self help groups.

TANSACS also provided support to private hospitals to cater to the needs of the community. It established five Community Care Centers at Vellore, Coimbatore, Tirunelveli, Thiruchirapalli and Namakaal districts. These centers involve NGOs and Trust Hospitals to serve as first referral units. Institutional Care Wards were created in medical college hospitals and in select District HQ hospitals to cope with the increased number of HIV/AIDS cases.

Care and support

The sharp increase in the number of HIV infections in Tamil Nadu made it imperative that the state provide clinical care and services to improve the social and economic well being of the people living with HIV/AIDS in addition to its focus on awareness generation. CST activities include clinical care particularly treatment of opportunistic infections, psychosocial support, building non discriminatory attitudes towards people at workplaces and educational institutes and definitive treatment through provision of ART. CST also includes attention to the needs of women living with the infection, having complete choice in making decisions regarding pregnancy and childbirth so that they can make appropriate informed decisions without coercion in one way or the other including prophylactic treatment for prevention of mother to child transmission.

Care in the early days:

1992 to the present:

The Government Hospital for Thoracic Medicine ⁴ (GHTM)

The relatively high numbers in coinfection of HIV and TB resulted in the movement of the care program from Government General Hospital, Fort to the spacious Tambaram Sanatorium as it was then called. The Tambaram Sanatorium, started in 1928 with 12 beds was taken over by the Government of Madras (Tamil Nadu) in 1935, to provide in-patient services for the growing number of TB patients. In 1976, the hospital was strengthened to more than 700 beds and was renamed as Government Hospital for Thoracic Medicine (GHTM) in 1986. In 1993, HIV care and support was initiated with the admission of two HIV patients into its wards. Center for Disease Control (CDC) formalized its collaborative project with the Government in 2002.

Since 1993, the hospital has been working towards training its medical and paramedical personnel on HIV disease diagnosis, care and management of HIV disease. Initial hesitation and fear gave way to interest in HIV disease and care on the part of the medical and other personnel. The center was selected by the Government for research on the use and role of the "Siddha system" an ancient indigenous system of medicare. The research apparently found that some of the drugs had immuno-restorative properties in HIV patients. These drugs are being used as staple drugs for all patients with HIV disease attending the hospital.

The GHTM houses or caters to the clinical needs of the largest number of HIV patients at one place in India. GHTM also treats patients from outside. A large number of HIV / AIDS cases have been detected and measures have been taken to treat opportunistic infections in an institutional set up. Government hospitals such as the GHTM, Tambaram have special care wards for HIV/AIDS patients. It has an inpatient capacity of 776 beds and 120 rehabilitation center that caters to the needs of just over one thousand inpatients in 31 wards. Apparently the number of staff has not increased at par since the 1980s to manage the large number of patients. One thousand patients visit the out-patient department for a regular OP and an HIV OP on a daily basis. Approximately 300 patients visit the HIV OP and over 300 patients receiving care and support in the 8 exclusive HIV wards (5 male and 2 female wards; with one for pediatrics). The center is especially skilled to manage chest diseases and is equipped to deal with every type of HIV disease.

GHTM has been vastly assisted by the contributions of NACO and TANSACS through equipment, testing kits, drugs for opportunistic infections, supplementary nutrition, training programs, and in establishing the Voluntary Counseling and Teaching Centers (VCTC). In 1997, the first skills building program was conducted for physicians responsible for AIDS management (PRAM) which was a hands-on training for 21 days leading to the further development and strengthening of the training center for training health care workers on the management of HIV disease.

In 1997, the center was designated as a National Training Center for HIV care and Support program. More than 55 medical officers have already complete the program and are now engaged in the care and management of HIV disease in other districts of Tamil Nadu. The hospital is connected to a large network of HIV/AIDS Technical Resource Group in India and partakes of discussions sponsored by UNAIDS and NACO on a weekly basis.

Patients have access to its services 24 hours. Management of patients at GHTM: The GHTM provides counseling, treatment of opportunistic infections for severely ill patients, anti tuberculosis treatment, siddha medication, PCP prophylaxis for out patients and antiretrovirals for seriously ill and advanced illness. Patients are given nutritious food diet and also receive additional supplemental nutrition from TANSACS. The center is equipped with an Intensive Respiratory Care unit for the management of patients who are acutely ill. Referrals are made to other public health units for specialized medical attention and surgical care. These patients are transported in ambulances to Madras Medical College, Kilpauk Medical College and Stanley Medical College. Patients recently diagnosed, asymptomatic or presenting with mild symptoms are advised regular follow up at the outpatient clinic.

The care shed provides accommodation and cooking opportunities for the care givers. Patients are given free Siddha drugs during inpatient care and during the regular monthly follow up. The center networks with non governmental organizations to provide rehabilitation and vocational training to women in sex work, destitutes, widows and AIDS orphans. CHES, World Vision of India and Missionaries of Charity are some of the groups that provide support to the GHTM.

Patients are charged according to their ability to pay while those with incomes less than Rs 1000 per month are treated free of cost. Most patients are from the lower socio-economic strata. Factory workers, agricultural labourers and members of the weaving community make up the majority of the patients.

Safe blood is advocated by encouraging voluntary blood donations and periodical blood donation camps and utilizing blood units for therapeutic use in the hospital.

Strengthening of GHTM, Tambaram with the support of CDC,

Atlanta and Government of India aims at improving the services of the hospital in management of HIV/AIDS cases. In-patient facility services, laboratory services etc. will be focused in this project, beside this hospital will function as an apex institute for training the medical and paramedical staff in the field of HIV/AIDS. The collaborative program aims to strengthen the objectives of the government program, provide training and capacity building for its human resources and positive groups and developing an MIS system for AIDS case reporting and monitoring.

In 2003, Sushma Swaraj, then the Union Minister for Health and Family Welfare announced a policy

and program commitment for providing antiretroviral treatment to 100,000 HIV infected patients, free of cost as of April 2004. Tamil Nadu considered a high prevalent state was selected for this first roll out along with five other states. This program initially prioritized HIV positive mothers to prevent mother to child HIV transmission, children below the age of 15 and patients with HIV seeking treatment in government hospitals. In Tamil Nadu, the need for additional centers prompted the government to expand from three ART roll out centers to thirteen covering the various districts of Chennai, Madurai, Namakaal, Salem, Tirunelveli, Thanjavur, Coimbatore, Theni, Trichy and Vellore. The roll out program is now available to all who require it based upon the clinical criteria as given by NACO for initiating ART. The ARV roll out was initially organized through referrals from NGOs and positive groups in Tamil Nadu. This roll out program has been effective in securing free antiretrovirals for more than 1000 patients; including children.

Besides the government, other health institutions developed their own approaches to caring for people living with HIV in line with the policy and guidelines set out by NACO and the WHO for resource constrained settings.

Use and abuse of Siddha and other forms of traditional treatment

There were reports that it is possible to seroconvert the HIV positivity of HIV positive persons by treatment by Indian system of medicines. These claims resulted in a lot of controversy and to verify and confirm these claims, a committee was constituted to review its plans with Dr Jayakar Paul as the chairperson. Three trials were conducted using Siddha medicines. A high protein and high fat diet was also given to the patients. The trial period was for two years. Adverse reactions were constantly monitored and the drugs were withdrawn when necessary and alternate drugs prescribed. Claims of cure by the Siddha Medicine Consultant were disproven as the western Blot and ELISA test results continued to be positive. Another claim for cure and control of Opportunistic Infections associated with AIDS was disproven and in fact the condition of the patients with infections like tuberculosis, candidiasis, herpes oro-genitalis and dermatomycosis became progressively worse. Patients presenting with Herpes Zoster seemed to improve with the Siddha medicines.

Further research has been conducted and presented at the 13th International AIDS Conference, Durban and currently GHTM provides Siddha medicines as staple drugs to all patients with HIV disease who do not have overt neural HIV presentations. These are used in combination with opportunistic infections controlling drugs. These formulations are made according to the "The Siddha formulary of India", Edition I (Govt. of India, Ministry of Health and Family Welfare, 1988). Over 35000 patients since 1992 have received these formulation with no adverse events and side effects. The drugs are apparently able to elicit similar responses to ART, like reduced viral load, increased CD4 counts besides responding well clinically in symptom control and increased body weight. These proponents no longer claim to have a cure but propose achievement of prolonged viral suppression in a few patients.

The center also conducts trials on patients using Siddha therapy hoping for a traditional low cost therapy to treat HIV infections. The success of the free roll out of the antiretroviral program has led to the government adding other ARV roll out centers at MMC and shortly at Stanley medical college as well.

HIV Care and Support in CMC, Vellore

The Christian Medical College, Vellore with its long history of vigorously combating stigmatizing diseases developed programs designed to maximize the effectiveness of HIV/AIDS treatment strategies with available drugs, prevent mother-to-child transmission, and to maintain a safe blood supply.

Christian Medical College and Hospital, (CMCH), Vellore, a 105-year old tertiary-care teaching institution with more than 1800 in-patient beds, and >1,000,000 outpatient visits every year, is renowned for its healthcare systems.

Since 1986, the team at CMC has been growing in its response to HIV care and support and have played a leading role in identifying ways and means of responding effectively to the challenges posed by this infection.

The Virology Department under Dr. Jacob T. John was designated as a "National AIDS Reference Laboratory" by Indian Council for Medical research (ICMR). The blood bank initiated routine screening of donor blood samples for HIV 1 antibodies in1987 for the first time in the country, much before it became a mandatory for donor screening. Experience with first few indigenous cases of AIDS underscored the need for a team approach to provide comprehensive medical care and the intensive psychosocial support required for the HIV infected individuals, as well as their families.

CMC was one of the first institutions in the country which formulated guidelines and policies, so that PLHA receive appropriate, effective and compassionate care in a non-stigmatizing environment.

CMC initiated a dedicated outpatient service for PLHA in 1988. The 'ID Clinic' is manned by staff from the departments of General Medicine Unit 1 and Infectious Diseases, Dermatology and Venereology, Child Health, Obstetrics and Gynecology, Psychiatry, counselors, social workers and pharmacists. The Clinic serves as a "one stop shop" to provide comprehensive, holistic care for PLHA. The services offered include:

- Voluntary confidential counseling and testing (VCCTC) services,
- Diagnosis, treatment and prevention of sexually transmitted infections,
- Diagnosis, treatment and prevention of opportunistic infections (OI),
- Nutritional counseling and interventions.
- Prevention of parent-to-child transmission (PPTCT) of HIV infection programmes,
- Antiretroviral therapy (ARV pharmacy, dedicated pharmacist, adherence counseling and monitoring),
- Psycho-social interventions (pre- and post-test counseling, supportive psychotherapy, economic support for PLHA in collaboration with partner NGOs)

HIV positive patients at Vellore are provided with all the appropriate treatments that are affordable using other less costly strategies to maximize survival time and quality of life. CMC Vellore was unique in initiating a system which refused to isolate HIV patients or refer them to specialty hospitals. This is a key policy that counteracts the social inclination to stigmatize them. The virology and clinical team work together in managing HIV disease; monitoring CD4 and viral load levels, detecting secondary infections and recommending treatments. The Obstetrics and Gynecology department team have a special program dealing with HIV+ women who are pregnant to in providing drugs to

reduce the chance of transmitting the virus to the newborn child. The pediatric department provides pediatric care to children with HIV disease.

The in-patient care specific to PLHA is provided mostly by the department of General Medicine Unit 1 and Infectious Diseases. Every effort has been made to ensure that care of PLHA is integrated (rather than segregated) - patients are admitted to the general medical wards, rather than to a separately designated ward, and routine medical care (for medical problems other than those related to the HIV infection per se) is provided by the specialties concerned. The team follows an algorithm-based approach to diagnosis and management of common OI in PLHA⁶.

Led by the Hospital Infection Control Committee (HICC), efforts were also initiated to provide a safe working environment for the medical staff. Policies were laid down regarding the practice of 'Standard Precautions', reporting of occupational injuries, and post-exposure prophylaxis for blood-borne viral pathogens. Immunization against hepatitis B virus is mandatory for all staff and students.

CMC is developing a mobile outreach program and hopes to become a regional supplier of blood, thereby minimizing the chances of spreading HIV through the blood supply in the Vellore area.

These efforts, by integrating 'HIV Medicine' into mainstream medicine, have inspired confidence among staff and patients alike, and ensured that comprehensive medical care is accessible and affordable for PLHA in our setting. We strongly feel that this is a cost-effective, sustainable and replicable model for health care for PLWHA in our country.

Training:

Being an educational center, the natural move was to develop a training program for clinicians and to incorporate HIV disease management

Management of HIV disease has been intergrated into the curriculum for undergraduate and postgraduate courses in Medicine, Nursing and Allied Health Sciences. The Virology Department is a regional centre for training of laboratory technicians in HIV testing. The HIV Psychosocial Resource and Reference Centre (located in the Psychiatry Department) provides regional and national training for counselors. CMC has thus been recognized by the NACO and WHO as a national training center of excellence. The faculty conduct training of state level medical officers and teachers of medical colleges on the initiation of ART, and has been selected as one of the four national centers for training of trainers (ToT) for the roll out of ART as part of the "3 by 5" initiative of WHO. Since March 2004, four such training programs were conducted in collaboration with the NACO and WHO. The faculty are also invited to conduct ART training by the state AIDS control societies in several other southern Indian states.

CMC initiated a Fellowship in HIV Medicine, a one-year training programme for doctors since 2002. A distance learning programme, it aims at improving the knowledge and skills of secondary hospital physicians thereby enabling the development of quality assured and accessible HIV services across the country. This programme is currently being scaled up, in addition to three other regional training centers (Grant Medical College Mumbai, Maulana Azad Medical College New Delhi and Kolkatta Medical College and the School of Tropical Medicine, Kolkatta). Training 25 doctors a year, the institute aims to have a center of AIDS treatment expertise in every district in India.

Lessons learned: CMC acknowledges that the success of their response to the HIV epidemic has been possible due to teamwork for comprehensive medical care, integration with the existing infrastructure, phased scaling up, capacity building, implementation of the written guidelines and policies, education and research.

HIV Care and Support at YRG Center for AIDS Research and Education (YRG CARE), Chennai

YRG CARE, a non-profit medical and research institution involved in the prevention of HIV for youth and high risk populations; provision of medical care and psychosocial support for more than 8000 persons with HIV disease in Southern India. It is known for its patient centered approach, its comprehensive service portfolio, its commitment to client and community education and its respect

for the dignity and privacy of its clients/patients.



YRG Medical Centre at VHS campus, Chennai.

YRG CARE in Chennai was one of the earliest groups in Tamil Nadu and within the country to initiate HIV/AIDS work. The hallmark of YRG CARE is in the evolution of its three main features; its self identity as a learning organization, constantly combining scientific research with grass-root level interactive educational approaches; its client centered approach governed by the vulnerabilities, experiences and needs of the people it services; and its extensive referral network with other medical institutional facilities and

individual providers for managing clinical and psychosocial support and with other NGOs and positive groups and networks for emotional and social support.

The main objectives of the center's care and support program are:

- 1. to offer stigma-free voluntary, confidential and anonymous, HIV counseling and testing
- 2. to provide people living with HIV and their friends/families psychological and social support
- 3. to give continuum care for people living with HIV/AIDS in a user friendly atmosphere.
- 4. to provide patients with access to quality low cost technologies for testing and monitoring which are viable in resource-limited settings.

Reference to YRG CARE begins way back in 1986 with the documentation of the first evidence of HIV in India and the onset of Tamil Nadu's response to the HIV epidemic. Founder- Director, Dr Suniti Solomon then the Professor of Microbiology at the Madras Medical College and her team documented first evidence of HIV in India. She responded to the need of the hour with prevention programs for youth, voluntary counseling and testing, and care and support within the public sector.

In 1993, Dr Suniti Solomon founded YRG CARE as a nongovernmental organization to meet with the needed autonomy and singular focus for engaging in full time AIDS related work, and meet with the increasing needs of people with HIV/AIDS and their families to live with dignity and halt the spread of the infection.

The wide spectrum of YRG CARE objectives and activities moved with the fast spread of the epidemic in Tamil Nadu. From the very beginning treatment and care were part of its response. Stemming from observations that PLHA faced two main obstacles; risk of exposure to frequent opportunistic infections and the need for its effective management and treatment, and the appalling stigma at medical institutions, YRG CARE mission is to respond to the needs of people who



are not receiving care and support or education/information about HIV under one roof.

VCT was one of the first initiatives in meeting with the care and support realm in 1993 ^{7.8}. Over a period of time, there has been a steady increase in the number of persons attending the VCT center. Pre and post test counseling and diagnostic testing was initially provided from a small apartment in the city. The center follows the policy of the NACO and WHO for the diagnosis of HIV. As the epidemic unfolded with emerging issues and discrimination, the center expanded its counseling program and now includes both medical related issues (treatment and adherence counseling, information for the prophylactic treatment to prevent mother to child transmission) and psychosocial aspects (marriage, reproductive choices, marital issues, family counseling and grief counseling). The center is now conscious of the increasing needs of children and youth who have lived with the infection over ten years; unaware of their status and its implications to their future and the decisions that they will need to make as they grow older.

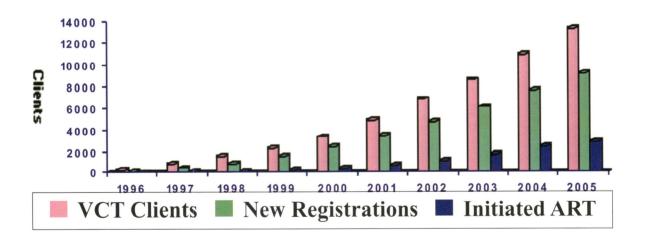


Figure 8: Trend of Voluntary Counselling and Testing at YRG CARE, Chennai

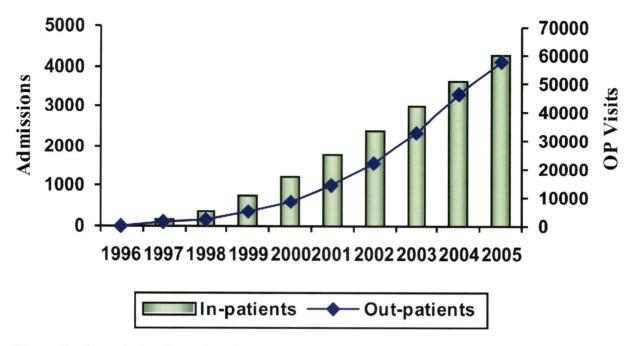


Figure 9: Cumulative flow of patients at YRG CARE, a tertiary care center in Chennai, TN

The center provides clinical care and management of HIV disease for a large spectrum of infections⁹ based upon the guidelines set by the NACO and the lessons learned from Asia and Africa as well as the developed world. The number of individuals seeking treatment has increased as the cost of antiretrovirals has decreased. The incidence of tuberculosis and opportunistic infections has decreased to <2 cases per 100 person-years between 1997 ad 2003 at YRG CARE (see figure below). Death rates decreased from 25 to 5 deaths per 100 person-years between 1997 and 2003¹⁰.

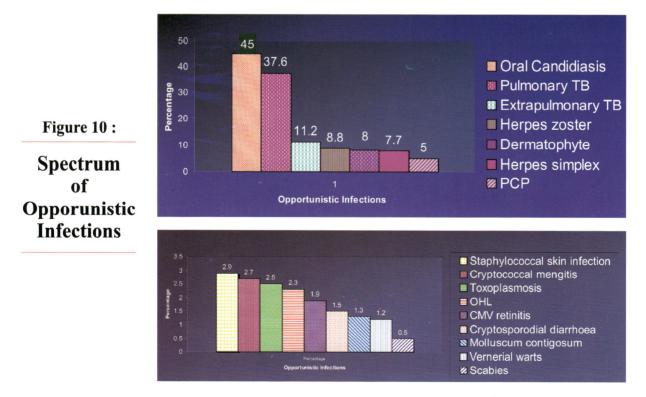
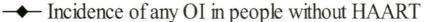
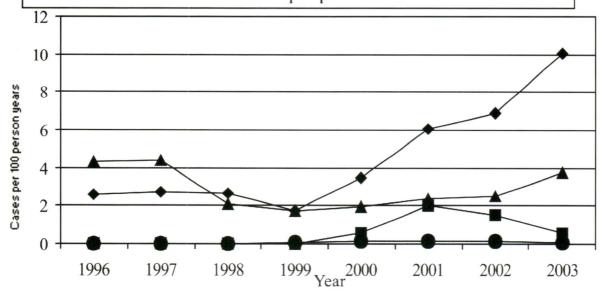


Figure 11: Incidence of opportunistic infection in patients with and without HAART, 1996-2003



- Incidence of any OI in people with HAART
- → Incidence of TB in people without HAART
- Incidence of TB in people with HAART



In 1997, the existing care program dependent on a couple of beds in private hospitals, expanded on securing premise at Voluntary Health Services, a community hospital in Chennai. At the same time, funding from AusAID supported care for the first time. This helped to strengthen the care program. Wrap Up, a periodic publication summarized new developments in HIV/AIDS care program relevant to the Indian context and provided physicians with access to updated information.

In the early years, treatment of opportunistic infections mainly catered to the male gender since few women came forward for testing. As the epidemic grew to the general population, in 1999, the center expanded its program to include a well women's clinic¹¹ and a pediatric ward and now caters to over 9500 patients. The clinic runs a 20-bed inpatient facility equipped with an intensive care unit and special wards, an outpatient department that responds to the counseling and clinical needs of its patients six day week between 8.30 am to 3.00 pm and a pharmacy which provides access to prescribed medications for opportunistic infections and antiretrovirals.

In 2000, the laboratory expanded to state-of-art proportions into an infectious diseases laboratory that is quality controlled and quality assured internationally. The fully functional laboratory includes biochemistry, hematology, virology, serology, microbiology, BACTEC for TB culture, mycology and immunology. It also does monitoring testing for CD4 count and Plasma Viral Load. It also offers drug resistance testing¹², measuring of incidence and evaluation of low cost techniques¹³ for measuring CD4 and PVL.

The increase in the number of patients accessing the care program has attracted attention of national and international research centers. The research program has expanded to meet with

the emerging needs of the PLHA community involving ethics, rights and consent for clinical and behavioural research programs and necessitated the involvement of an Institutional Review Board (1999) and a Community Advisory Board (2000) to review and guide its progress.

Besides voluntary counselling and testing, the center also provides other psychosocial support and counselling to



Laboratory Set-up at YRG Care

individuals, couples and families in the areas of nutrition, adherence, fertility, marriage, disclosures issues, domestic violence, etc¹⁴. Recently the center has expanded its service to include group psychosocial support for women.

The center also provides home care which includes again a holistic approach; clinical and psychosocial support. Begun in 1994 for those who were terminally ill or pregnant, it is also available to those who do not want to come to the center out of fear of being identified. The team travels to the homes un-uniformed and using public transport to protect the confidentiality and privacy of the families that they visit.

Referrals are made to a consortium of consultants for specialised management and these professionals are well informed about HIV disease and are sensitive to the issues surrounding people living with HIV.

Patients travel long distances to access care and this increases the disease burden in terms of travel costs. Time out of work also contributes to the crippling impact of HIV disease on the person and the family. Thus, YRG CARE sought to replicate its concept of a continuum of care model to other states in Southern India ¹⁵. Four sites in Southern India were selected and trained to meet with this need. Through this operations research ¹⁶ and scale up program, YRG CARE was able to document its base model on care ¹⁷ and provide a scale up program (1999-2003) for NGOs and CBOs in Southern India (Asha Kirana, Mysore, SFDRT, Pondicherry, Calicut, Kerala and Shadows, Chirala.)

YRG CARE has over 100 journal articles and book publications to its credit, each one highlighting its response to HIV disease. In 2000, YRG CARE documented HIV disease in India - two publications published by the East West Publications (P) Ltd. have contributed much to the documentation of the natural history of HIV in India as well as serves as a tool for clinicians involved in HIV care. The Colour Guide 18 is a colour atlas on common opportunistic infections and the Treatment Guidelines 19 includes the diagnosis and management of a wide spectrum of opportunistic infections commonly seen in the

Indian population. The Treatment guidelines include prophylactic, therapeutic and management considerations in HIV disease as well as psychosocial support and ethical issues in treatment. Clinical acumen from YRG CARE ever since has helped contribute immensely to further documentation at the national level as well as consultation with the World Health Organization for further enhancing HIV management in developing countries. These publications have helped disseminate and train several clinicians in Southern India and other parts of the country and South East Asian countries in the management of HIV disease in resource constrained settings. The documents are based on the NACO/WHO guidelines for care in resource poor settings. Recently, the center contributed to the WHO's initiative in developing a guideline for resource constrained settings on the HIV diagnosis and monitoring of antiretroviral therapy²⁰.

Along with care and treatment, the center also provides access to hands-on training and capacity building of personnel as well as training and scale up of external clinicians, counselors and laboratory technicians; governmental and nongovernmental from India and other South East Asian countries. The clinical and research team are invited to regular CME and other training programs by the government, NGOs and universities both locally, at the national and international level.

YRG CARE is one of the four sites and the only site for Tamil Nadu awarded the GFATM involving public-private partnerships for enhancing antiretroviral therapy for a period of five years covering 1000 patients per year and encourages patients to join according to their ability to pay for antiretroviral therapy based on a graduated cost recovery program. Constant networking and fund raising have led to other smaller programs that allow for free access to antiretrovirals to those who need it for a limited duration allowing them to effectively regain their health and return to gainful employment thus giving them the ability to manage their own treatment costs.

Liaisons have been mainly with the scientific community within the country and international experts, other NGOs, the governmental sector, international donors, industries, media, celebrities, PLHA groups and the community at large.

The organization faces challenges involving financial stability to sustain the organisation's activities and quality of services based upon an increased public demand for quality HIV/AIDS services.

South India AIDS Action Program (SIAAP)

In the early phase of the epidemic in Tamil Nadu, SIAAP spearheaded in its initiatives on activism and advocacy for the rights of the women in sex work who were illegally detained at a remand home follow up to their HIV diagnosis. In a landmark judgment, the Madras High Court ordered the release of the 800 detained women and the State further passed a ruling that no individual could be held on grounds of their HIV status. Success at their initial challenge led to advocacy and counseling programs for women in sex work (SW) and was extended to other vulnerable and marginalized communities like truckers, eunuchs, men having sex with men (MSM) and people living with HIV (PLHA). The activism led to the impetus to address the sexual and reproductive rights of these people and SIAAP encouraged the participation of the grassroot communities to strengthen these institutions and develop their capacities.

Over the years, the center has provided guidance and counseling to several organizations in

Southern India; governmental and nongovernmental; strengthening and expanding its programs. Since 1997, their a one-year, on the job, diploma training and supervisory programme has helped over 200 counsellors provide services at nearly 100 district Government Hospitals in Tamil Nadu, Andhra Pradesn, Karnataka, and Goa.

Between 2000-2004, SIAAP organized the training, supervision, and recruitment of counsellors for the VCCTC, PPTCT and Blood Bank counselling programmes. This training and capacity building initiative recruited 100 counsellors for Tamil Nadu HIV/AIDS programmes. Mid epidemic, SIAAP experienced a burnout phase, wherein management and personnel felt the need for a shut down for a much needed period of rest and reflection. The reputation of SIAAP attracted national and international institutes working on HIV/AIDS policy and practice. Linking with other NGOs and incorporating HIV into their programs has led to setting up of over 60 programs in Tamil Nadu and the neighbouring states of Karnataka and Andhra Pradesh; with an outreach of 1 lakh persons in each state.

SIAAP encourages communities to take on advocacy efforts and build equitable partnerships and discuss relevant and community specific agendas. The center has helped register community organizations in Tamil Nadu that constitutes vulnerable and marginalized people who have been empowered to be able to come together on a common agenda. SIAAP has initiated 20 functional community organization for women in sex work, gay or bisexual men, people living with HIV and blind people. For medical services, SIAAP networks with the government and other NGOs and believes in strengthening these institutes rather than creating parallel systems.

Community Owned and Managed Organisations (COMOs)

The COMOs programme supports in the formation of new community organisations and also strengthens & builds the capacity of existing organisations. Many people are unable to seek proper treatment and care because there is insecurity and obstacles to accessing money. Banks and moneylenders are often hard to access, demoralizing, and exploitative. Thus, SIAAP developed schemes to address ways for people to save money that exemplifies respect, equality, and accountability. The thrift and credit society is managed by the local communities and brings people together, helping them to save their money and access loans.

SIAAP also runs a Short stay facility The Selvi Memorial Illam Society (SMIS) at Tambaram Sanatorium, which provides PLHAs and their attenders decent accommodation and hygienic food facility at a reasonable cost. The team also coordinates with the Community counselling centre, the first of its type since 2004 at Alandur, Chennai.

Overall, SIAAP has focused on advocacy and empowerment and training of vulnerable populations in the areas of sexuality, gender, human rights and in identifying specific technical skills that will help them find solutions to their problems.

The Community Health Education Society (CHES)

When Dr.Manorama decided to open her home to two HIV-infected orphans, she set in motion a series of events that would establish CHES as a care-giver for HIV/AIDS infected persons.

The Community Health Education Society (CHES) is a Chennai -based NGO that offers refuge and solace to HIV/AIDS patients in general and infected women in particular. The Ashram was CHES' initial project and was started as a home for AIDS orphans. Over the years, the Ashram also became a place of refuge for CSWs. Many have left the sex trade and work as care-givers at CHES.

Caring for HIV/AIDS patients involves an approach that must minister to their physical, mental, emotional and spiritual needs.

In 1997, CHES began its home-based care programme. Named Vidiyal (dawn), the project also runs the Hope Club with support from TANSACS.

CHES is funded by TANSACS and has networked with organizations working in other fields. For instance, it sends drug users to the TTK hospital to be detoxified. In return, CHES provides TTK with counselling services for HIV persons. CHES uses YRG Care's AIDS detection testing facilities. The Banyan, an NGO that works with destitute women, refers HIV positive cases to CHES, which, in turn, refers women who do not need medical treatment to The Banyan, CHES also networks with a variety of spiritual organizations.

Dr P Manorama provides shelter care to women and children affected by HIV. Residents at the Ashram as it is called receive spiritual counseling and educational support. CHES also includes a clinical wing, Raasi which is a private institute for out patient care and counseling.

CHES's role in care and support provides alternatives to risk taking and risk activities for many of its residents.

Challenges to care:

The early years of the epidemic gave rise to the notion that HIV was a disease of only sex workers, truckers and injecting drug users. This prejudice increases the denial of the disease, increases vulnerability and marginalization of these populations. These issues affect harm reduction strategies, perception of ones risks and encourages mushrooming of magic cures without scientific evidence.

Stigma is still highly prevalent in the health sector. Poverty and lack of empowerment of women contribute to the disease burden and access to treatment.

Providing HIV /AIDS patients with an emotionally stable, happy and supportive environment goes a long way in keeping them healthy. Initially, due to the stigma and ignorance, many lost their livelihood. The fear psychosis built around the infection resulted in even hospitals refusing to admit or treat HIV positive people. Many patients would lose their will to live or live in abandonment. But with the advent of generic HAART at low cost many more are able to access treatment, and lead a good quality of life. Though Tamil Nadu has one of the largest number of HIV cases recorded in the nation, the government, the non governmental organisations and self help groups of people living with HIV have networked well and responded actively especially on advocacy issues and in the care, support and treatment of people living with HIV.

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PARTNERSHIP IN PREVENTION, CARE, SUPPORT AND TREATMENT OF HIS AND STREAM AND

Dr.Kurien Thomas - Dr.Sudhakar Kurapati

n the early phase of the HIV epidemic leaders in Tamil Nadu realized that HIV/AIDS is not only a health problem but a social and developmental problem requiring a multi-dimensional response. While the epidemic was evolving in Tamil Nadu, global evidence was also emerging, that concentrated efforts from the public sector, the private sector and civil society including PLHA is crucial if the spread of the disease is to be controlled. In addition, developmental partners played a crucial role in emphasizing the importance of partnerships as an integral part of disease control strategy and the consequent need for building capacity of different stakeholders in the state. This resulted in mounting a major multidimensional response. It must be noted that from the beginning Tamil Nadu has had visionary leaders who facilitated partnership development based on mutual trust and shared benefits. A number of institutions and systems were strengthened to deal with the emerging situation. Civil society which played a significant role in the state on developmental issues also became engaged in HIV/AIDS and helped to bring a sense of urgency to the response. The TANSACS which was established in 1993 and APAC project established in 1995 and supported by USAID, provided a system to bring together the major players from throughout the state to wide area of HIV/AIDS areas.. Their leadership lead to a higher degree of collaboration than seen in many other parts of the country. This document cannot do justice or bring to focus all the partners who have been a part of the response. Instead, it attempts to provide a historical description of the response and describe the contributions of a number of the partners who were involved in the early response to HIV/AIDS in Tamilnadu.

Partnership at Program Level:

Under the leadership of the State of Tamil Nadu Department of Health and Family Welfare, two of the major players spearheading the response to HIV/AIDS were the TANSACS supported by the NACO and APAC of VHS supported by the United States Agency for International Development (USAID). TANSACS being the apex body has consolidated all the partners with the formation of Partners in Action Consortium to synchronize their activities and avoid duplication of efforts. This forum provides a platform for sharing information among various stake holders in the state. Working in collaboration the two organizations, supported and facilitated innovative and interventional programs among various population groups with high risk behavior in the state, supported the development of IEC for the general population, strengthened health services and condom promotion. Visionary leaders like and Mr, S.Ramasundaram and S. Allauddin from the government and Dr.N.S. Murali and Dr. P. Krishnamurthy from civil society recognized and responded to the HIV epidemic aggressively and early.

Partnership of Academic and Research Institutions:

Academic institutions were the first to respond to the potential threat of HIV/AIDS in the state. They not only played a crucial role in the early identification of the HIV and it's spread in the state but also laid down the principles of delivering key health care interventions in the state. Among the many

institutions engaged in the response were the Christian Medical College, Madras Medical and Dr. MGR University. The ICMR it's and institutes in Tamil Nadu, particularly the TB Research Centre (TRC) and National Institutes of Epidemiology (NIE) provided support in strengthening surveillance and research on HIV/AIDS in Tamilnadu. The Madras University initiated the University Talk AIDS program in the early part of the epidemic and helped to improve the knowledge base of the community. MGR Medical university, Madurai and



HIV / AIDS - IEC Program for Students

Coimbatore medical colleges are other important partners who have played a key role in health delivery and strengthening this partnership. A landmark survey was conducted by a consortium of

academic and medical institutions (INDIACLEN network) in partnership with Christian Medical College (CMC), APAC, Post Graduate Institute of Basic Medical Sciences (PGIBMS) and Meenakshi Mission Hospital and Research Centre (MMHRC) generated important information about the prevalence of HIV and sexually transmitted diseases in the general community.

NACO USAID/US Gov HHSCDC Ministry of Health TN UNICEF NGO **VHS** WHO **PWDS GHTM Transport** Corporation YRG **CAPACS** NGO NGO Ministry of Education **FHI TNSACS APAC** NGO Ministry of Youth Affairs NGO NGO **PSI** Railways PLHA Networks HLL **Private MMC Clinics MGR** CMC University **Private** ORG Industry **AYUSH** Hospitals **Madras** Informal University IMA **Providers** Academic **Private Medical Private Sector** Community **Providers**

Figure 12: Major Tamil Nadu HIV/AIDS Network 2004:

Partnership of Government Departments:

Mainstreaming the response against the HIV/AIDS epidemic through partnership between various government departments has been more successful in Tamilnadu compared to many other states. Even though the effort had its limitations, a great deal of momentum was generated due to the active participation of other government agencies and departments. For example, the education department in the state through support from UNICEF effectively undertook the school AIDS program (TN PIP NACP III); The transport department supported the effort of APAC in strengthening the prevention programs among auto-rickshaw drivers and truckers. In addition, awareness campaigns and local initiatives for care, support and treatment have been undertaken by the state and district administration. to 275 PPTCT centers, 28 HIV/TB coordination committees to control HIV/TB co-infection (TN PIP NACP III). TANSACS has developed a behavioral intervention program that proposes to equip women members of Self-Help Groups with adequate knowledge about HIV/AIDS/STI and necessary capacity and skills required to make informed decisions on their sexual and reproductive health. This Project covers 3,100,000 women in almost 1,55,000 Groups in the State. TANSACS works in collaboration with the Tamil Nadu Corporation for Development of Women, for effective and sustained reaching of women in rural areas and through them the community at large with the support of CDC. The Program is expected to benefited 35 lakh socio-economically disadvantaged women in rural areas in the State and through them the community at large.

NGO Partnership in prevention and care:

NGOs were the primary vehicle for delivery of prevention programs particularly among the groups at higher risk (i.e., targeted interventions) in Tamilnadu. By 2004, there were sixty six targeted interventions being implemented by these NGO partners. While the capacities of NGOs to undertake complex interventions were initially limited, the enthusiastic efforts by NGO partners to learn and improvise helped the program to develop effective interventions. Capacity development efforts by USAID, FHI and other leading institutions of Tamil Nadu assisted the NGOs to understand the importance of quality assurance in service delivery. Although challenges remain, epidemiological and behavioral surveys have shown that the NGOs have contributed substantially to the overall response of the state, by reaching individuals at greatest risk with appropriate behavior change counseling and providing services needed for effective and sustained behavior change.

International NGOs

A large number of national and international NGOs have provided technical and programmatic support for the HIV/AIDS efforts in Tamilnadu. Among them, Population Services International, India (PSI), Project Concern International India (PCI), PWDS, Family Health International (FHI) are some examples of NGOs who have worked in collaboration with local NGOs in prevention and care and support.

PSI India:

Indian projects facilitated by PSI are funded by USAID, DFID and Bill and Melinda Gates Foundation, PSI works with local NGOs to implement its programs and projects. Operation Lighthouse (OPL) is a USAID supported Project in Tuticorin and Chennai ports. With funding from Gates foundation, PSI helped to run STI clinics in 13 districts of Tamil Nadu where doctors are being trained and franchised

Partnership in Prevention, Care, Support and Treatment of HIV/AIDS Epidemic

for STI and HIV care. The program also supports condom social marketing in 11 districts of TN. To raise awareness in population between the age groups of 18 to 45 years, a special campaign called . Pulliraja was launched in 2004 as a part of the communication strategy in eight cities across Tamilnadu supported statewide with similar messages on the television.

Project Concern International India (PCI)

Established in India in 1997, PCI, India has been carrying out prevention and care activities in Tamilnadu since 2002. Working in Salem District, PCI is implementing 5 projects in collaboration with local partners, including PATHWAY, BRIDGES, TAI-VHS-FSW Programme, Community Care Centre and Salem Network of Positive people (SNP+). The project, a CDC-GAP assisted initiative, delivers home-based HIV/AIDS care and support to improve the quality of life of PLHA in the selected low-income communities in Salem District. The project provides access to VCT and provides mobile clinic and home visits, prophylaxis and palliative care, drop in centres and nutritional support. Referral linkages have been made with the District Hospial and local providers when hospitalization is necessary. When free antiretroviral treatment became available in 2004, PATHWAY assisted PLHA to access treatment at GHTM, and more recently at the Nammakkal District Hospital. The project has established adherence support groups, and in collaboration with the SNP+ is providing psychosocial support and assisting PLHA to live positively.

PWDS Alliance:

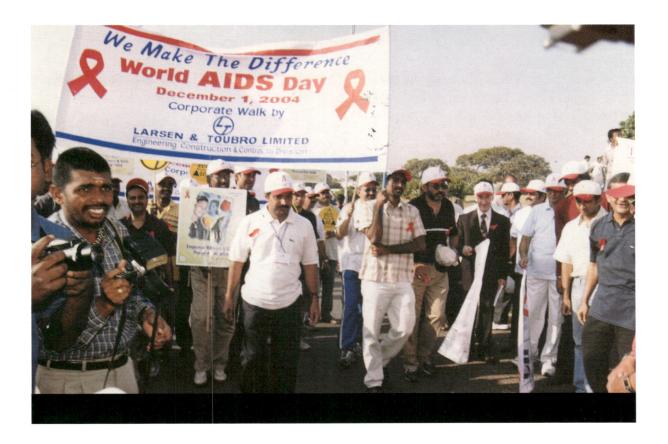
PWDS-Alliance is supporting community-based care and support projects for orphans and vulnerable children in Tamilnadu. Supported by Abbott Laboratories, USA, and the European Union, and with technical assistance from the International HIV/AIDS Alliance, UK, PWDS provides psychosocial support, health care services, VCT services, food and nutritional support, economic support, emergency relief, capacity building activities and services to children who are infected and affected by HIV/AIDS. PWDS reaches the economically weaker sections in rural areas of 13 districts in Tamil Nadu with 20 community based intervention NGOs (NGOs). The NGOs in turn work with other NGOs and CBOs, which include two hospitals and one hospice. The projects cover the districts of Erode, Namakkal, Coimbatore, Karur, Tiruchi, Dindugul, Teni, Madurai, Virudunagar, Ramanathapuram, Tuticorin, Tirunelveli and Kanyakumari.

Family Health International (FHI)

FHI is an international NGO working in Tamil Nadu and Pondicherry with NGO partners particularly in OVC, IDU and MSM projects. With financial support from USAID, FHI played a key role in building the capacities of smaller NGOs and in providing technical assistance to APAC funded NGOs when APAC was first established. Another important achievement of FHI has been the mobilization of women's self help groups (SHG), which are essentially micro-finance groups and very influential in their localities. Working in Tamilnadu and Mumbai, FHI also supports a source-destination migrant intervention project targeting individuals migrating between Tamilnadu and Mumbai. FHI is supporting projects in the high prevalence areas of Chennai city and Theni, Madurai, Tirunelveli, Namakkal and Salem districts.

Partnership with Industry and Other Private Organizations:

Condom manufacturers and social marketing organizations have played a significant role in the TN response. As a result of the combined efforts of Hindustan Latex Limited (HLL), J.K. Chemicals and



TTK Health Care, and in collaboration with the National Institues of Sales, a large number of traditional and non-traditional condom outlets were established, leading to a substantial increase in the number of condoms that were sold in Tamilnadu. The National Institute of Sales developed a training program to develop the skills of condom retailers. NGOs were trained in social marketing issues. Professional communication campaigns were launched with the help of leading professional agencies. In addition, HLL was supported by both TANSACS and APAC to strengthen the overall condom promotion efforts.

Partnership of APAC with ORG Marg (note: BSS has been carried out by a number of different agencies might want to state with professional organizations) has resulted in 9 rounds of behavioral surveillance surveys (BSS) successfully conducted in the state. Similarly, and in collaboration with APAC, TANSACS has supported 8 rounds of the BSS in rural areas and among the general population. These survey have provided valuable information to fine tune program implementation, revise communication campaign contents and materials and modify other strategies of both TANSACS and APAC at various levels.

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Private health providers at the level of individual or solo practitioners and in clinics and nursing homes are the main providers of STI treatment in the state. .Both APAC and TANSACS partnered with these preferred providers and developed their capacities to deliver better quality of STI services to the clients.. In this effort institutions like Gandhigram and Madurai Meenakshi Hospital, Medical College, Coimbatthore and TN Voluntary health Association of India (THVHAI) played a crucial supporting role.YRG Care has played a crucial role but is dealt in greater details in the section on care support and treatment.

Partnership with Civil society Leaders and PLHA network:

In the fight against HIV/AIDS many civil society leaders in TN have extended strong support for the activities undertaken in the state. The movie industry has a strong influence in the Tamil Nadu psyche and it was of great significance that movie idols like Rajani Kant, Kamalahassan & Revathi came to the fore front for mobilizing HIV support and advocacy and strengthening the hands of APAC and TANSACS programs.

PLHA network has also been very active in Tamilnadu and contributed significantly to directing the response of the state. With support from USAID/FHI, The Indian Network of Positive Ppeople was established in Chennai the national headquarters of INP+ have remained in Tamilnadu today. Other related networks, such as the Positive Women's Network have also been established and are headquartered in Chennai. The state provided the necessary enabling environment for such networks to establish and expand in an organized way. The PLHA networks have played a crucial role in the fight against stigma and discrimination, and lead the campaigns for positive prevention. The high prevalence district of Namakkal, Theni, Erode, Cudalore, Madurai, Salem and Tirunelveli have well established district networks of more than 500 members. The other districts have smaller networks partnering the state in prevention and care and support activities. TNSACS and the major organizations have developed strong collaborations with PLHA networks.

Technical Agencies and Developmental Partners

Having a unique position in the history of HIV/AIDS epidemic in India, the state was fortunate to have the active support of technical agencies from the national and international level.

Indian Council of Medical Research (ICMR):

ICMR played a crucial role in strengthening national and state level HIV surveillance systems in the 1980s and 1990s. The support to the program from Dr.Ramalingaswamy DG ICMR in setting up the surveillance systems and University Talk needs special mention. Subsequently ICMR has played a crucial support role to TNSACS in developing and strengthening the HIV/TB co-infection strategies and in providing ongoing support to the surveillance program.

The World Health Organization (WHO)

At the international level WHO was the key partner in the early part of the epidemic in the state. They brought to focus the international experience and lessons to bear on the development of the AIDS response in the state.

United States Agency for International Development (USAID):

Tamilnadu developed as a focused area of interest for USAID in India particularly in the HIV/AIDS activities. USAID and their technical partners, especially FHI played a crucial role in strengthening the NGO response in the state. The system of targeted interventions and evidence based planning carried out by VHS APAC has been replicated within the state and country. The APAC project advisory committee is co-chaired by the Secretary of Health, Tamilnadu and has lead to a well-coordinated program within the state. This successful model is being replicated in other states like Maharashtra through AVERT program. The leadership shown by Mrs.Linda Morse, Dr.Rekha Masilamani (USAID) and Dr.K.Sudhakar (USAID) in the early phase of the partnership contributed significantly to the success of this partnership.



Health and Human Services/Centers for Disease Control:

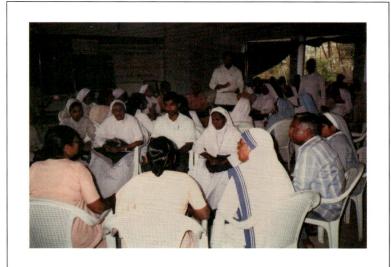
The Global AIDS Program (GAP) of U.S. Centers for Disease Control and Prevention (CDC) initiated activities in 2001 at the request of the Tamilnadu government. Since then, in collaboration with TANSACS, CDC (GAP) has developed programs to build capacity and strengthen infrastructure for HIV prevention, care and treatment within the public sector. Major project support has been in at the GHTM to build it's capacity to become a center of excellence in HIV care and treatment. CDC-GAP has also supported the network of positive people to develop family counseling centers and programs for positive living in Tamilnadu and replicate these in other states. Dr.Dora Warren from CDC played a key role in providing leadership to this effort.

Bill and Melinda Gates Foundation (AVAHAN)

The Bill and Melinda Gates foundation has been a more recent entrant to the activities of the state. In collaboration with Tamilnadu AIDS initiative (TAI), the foundation has started a project in 2004 that delivers BCC, Quality STD Care, Condom promotion and collectivization of the beneficiaries in five intervention areas. There are two clinics for STI treatment facilities run with TAI support. There are plans of integration with a larger network of medical practitioners across the project area.

Conclusion:

A wide range of public an private institutions; governmental and non-governmental organizations; financial and technical support agencies, bilateral and multi-lateral development agencies have joined hands to orchestrate the Tamil Nadu response. The multidisciplinary inputs received from these groups have enabled the state to understand the dynamics of the epidemic, the geographical and community level variations and socialcultural and political implications



Religious Organisations in HIV/AIDS IEC Programs

of HIV, as well as to develop and implement appropriate responses in prevention and care.

Demographically Tamil Nadu is almost the same size of Thailand and in a variety of ways emulated the successful management of AIDS control program in Thailand. To accomplish the stabilization of the epidemic leading to subsequent decline, Thailand mounted a major effort through the leadership of Mechai Viravadiya and others with substantial financial inputs over seven years. In Tamil Nadu, similar results were obtained with the help of a spectrum of organizations and at a relatively lower cost and more importantly in a relatively shorter timeframe.

Tamilnadu will need to continue to sustain and strengthen the partnerships consolidate the gains achieved so far. More attention will need to be given to developing cross-border activities, sharing of information to develop effective strategies and integrating prevention and care/support strategies.. A State level partnership forum with periodic meetings and conferences will be able to create a sustainable platform for the partners to exchange, debate and develop and consensus on various emerging issues and assist the state in further strengthening the response to the HIV/AIDS problem.

Types of Partnership in Tamilnadu

1. 1. NGOs and Civil Society

- 1. APAC /VHS- Preventive strategies in Truckers, Sex workers, MSM, slums and migrants and also with youth in designated districts
- 2. Sixty Six Targeted Interventions for High Risk Groups in Tamilnadu by different NGOs
- 1. PSI Project Light House in the port areas of Chennai, Tutucorin and also in the district of Namakkal
- 2. PWDS Alliance working on care and support in 13 districts with 20 NGOs
- 3. YRG Care
- 4. TAI

2. Academia

- Christian Medical College in epidemiological evaluation, Community Surveillance of STD and HIV, Capacity building of personnel, Other Technical support, Test Kit Evaluation
- Madras Medical College
- ❖ Gandhigram STI Training
- Annamalai Univeristy
- ❖ Madras University Increasing awareness through university talk AIDS
- Tamilnadu Dr. MGR University Organizing national and International meeting of stake holders
- St.Johns Medical College Evaluation of interventional programs in the state

3. Private Sector

- Hindustan Lever in Social marketing of condoms
- ORG Marg with mapping and Behavioral Surveillance Survey
- National Institute of Sales in training of retailers

4. Developmental Partners and International Agencies

- 5. WHO Providing technical support
- 6. United States Agency of International Development through APAC
- 7. CDC GAP –Building capacity and infrastructure prevention, care and support and strengthening monitoring and evaluation systems
- 8. UNICEF is funding School AIDS Education Program (SAEP) and has is piloting the Namadhu Gramam scheme in 100 villages in Krishnagiri district. Provision of Technical Assistance for PPTCT.
- 9. Student Partnership world wide Youth Activities in 2 districts of TN
- 10. FHI Support to developing the capacities of PLHA network as well as certain care and support programs especially among affected and infected children
- 11. Futures Group under the Essential Advocacy Project -Providing assistance in Advocacy and capacity development
- 12. Bill and Melinda Gates Foundation working with Sex workers (both male and female), and MSM in designated districts through Tamil Nadu AIDS Initiative

5. People Living with HIV/AIDS

- 13. Well developed Network of more than 500 members in 6 districts
- 14. Formative and smaller networks in other 24 districts of the state.

6.Other

- 1. Transport Corporation Of India Foundation is implementing truckers intervention along the highways
- ICMR TRC providing leadership in issues related to HIV/TB interactions and guidelines for nutritional support for PLHA
- 3. Railways Supporting preventive and CST activities of the government
- 4. Individual like Rajani Kant, Kamalahassan & Revathi for mobilizing HIV support and advocacy

LIST OF PARTNERS WITH DETAILS

APAC Partners- IIP Targeted Intervention Programs through NGOs

SI. No.	Name & complete address of NGO	District	Area of operation Block & city
1	Native Medicare Charitable Trust, (NMCT) Somayampalayam, Coimbatore – 641 108	Coimbatore Dt.	Thudiyalur block
2	Rural Interdisciplinary Development Society (RIDS) Perianahalli Dharmapuri – 635 205	Dharmapuri Dist.	Hosur
3	Villages Education And Economic Development Unit (VEEDU) Savoor, Vellore Dt 632106	Vellore Dt.	Ranipet
4	Community Action Trust, (CAT) Velacherry, Chennai 600 042	Chennai Dt.	Manali area
5	We Care Social Service Society (WCSSS) Singaperumal Koil – 603 204. Kancheepuram District	Kancheepuram Dt.	Guduvancherry
6	Society for Education and People's Action for Development (SEPAD) Vellakoil, Erode District	Erode Dt.	Bhavani
7	Madurai Non Formal Education Center (MNEC) 15, Fathima Nagar, Bye Pass Raod Madurai – 625 016	Madurai Dt.	Madurai town
8	GRAMIUM Kanakkapillaiyur Papakkapatty – 639 119 Karur Dt. Tamil Nadu	Karur Dt.	Karur town
9	The Society for Social Justice & Human Resource Development 565, M.G. Road. Pondicherry – 605 001	Pondicherry Union Territory	Pondicherry town

APAC Partners- Migrants Project

1	Social Awareness and Voluntary Education,(SAVE) 5, Iswariya Nagar, Dharapuram Road, Tirupur, Coimbatore – 641608	Coimbatore Dt.	Tiruppur town and surroundings.
2	Near Byepass Road, Opp: NTC IL Main Gate, Koodamkulam, Tirunelvei Dt.	Tirunelveli Dist	Koodamkulam and surroundings.

APAC Partners- MSM Project

1	Sahodaran Ellaimman Koil St., Pondicherry	Pondicherry Union Territory	Pondicherry and Karaikkal
2	Social Welfare Association for Men (SWAM) No.12/5, Nataraja Street, Balakrishna Nagar, Jafferkhanpet, Chennai – 600 083	Chennai Dt.	Chennai Corporation area 10 main sites and 21 subsites

APAC Partners - SIP Project

1	Imayam Social Welfare Association, Ganapathy, Coimbatore - 641 012	Coimbatiore Dt.	Coimbatore town and Ganapathy - 25 slums
2	Empower, Subbiahmudaliarpuram Tuticorin - 628 003	Tuticorin Dt.	86 slums spread over Tuticorin Town
3	Association for Rural Development, (ARD) Nagamalai Pudukottai, Madurai - 625 019	Madurai Dt.	24 slums in Madurai Town.
4	Deepam Educational Society for Health (Desh) Thiruvanmayur Chennai, - 600 018	Kancheepuram Dt.	22 slums in spread over Alandur and Pallavaram
5	Bro Siga Social Service Guild Vyasarpadi Chennai - 600 039	Chennai Dt.	18 slums spread over North Madras Vysarpadi
6	Institute of Self Management Gnanaolivupuram, Madurai - 625 016	Madurai	28 slums in Madurai Corporation area
7	People's Development Initiatives (PDI) Beemanagar, Tiruchirapalli – 620 001	Tiruchirapalli Dt.	60 slums spread over Tiruchirapalli Corporation area.
8	Bharathiya Adim Joti Sevak Sangah(BAJSS) Vivekananda Nagar, Pondicherry, 605 005	Pondicherry Union Territory	62 slums spread over Pondicherry town
9	Village Beneficiries Education and Development Society (VBEDS), Varichikudy, Karaikal – 609 609	Pondicherry Union Territory	87 slums spread over Pondicherry town
10	Upliftment of Democratic and Village Improvement Society (UDAVI) Anna Nagar East, Chennai – 600 102	Tiruvallore Dist	18 slums in and around of Mugapir area.

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APAC Partners - TWIP Project

1	Madras Social Development Society (MSDS) Poonamallee, Chennai - 600 056.	Tiruvellore & Vellore Dts.	Tiruttani, Sholigar Arakonam & surrounding areas.
2	Scientific Educational Development for Community Orgn.,(SEDCO) Sattankulam, Toothukudi Dt 626 704	Tuticorin Dt.	Tiruchendur, Kayalpattinam Udangudi.
3	Voluntary Educational & Economical Development Organisation (VEEDO) 74, Bharathidasan Nagar, Kancheepuram - 631 502.	Kancheepuram Dt.	Kancheepuram Town
4	Indian Community Welfare Organisation (ICWO) Mamallapuram Kancheepuram Dt.	Kancheepuram Dt.	Mamallapuram & Kovalam & sububs.
5	Community Action for Social Transformation (CAST) Cheranmahadevi Tirunelveli Dt 627414	Tirunelveli Dt.	Courtallam, Thenkasi, Sankarankoil, Senkottai Ambasamudram, Kadayam Kadayanallur, Sendurai
6	Center for Human & Natural Resources Development (CHANARD) Kodaikanal, Dindigul Dt.	Dindigul Dt.	Kodaikanal Town and surroundings.
7	Madhar Nala Thondu Niruvanam (MNTN) Pathirikuppam Cuddalore – 607 401	Cuddalore Dt.	Chidambaram, Sirkali Vaitheeswaran Koil and surroundings.
8	Association for Integrated Rural Development (AIRD) 1/960, Avvai Street, Ramanathapuram – 623 503	Ramanathapuram Dt.	Rameswaram, Earvadi Surroundings
9	Rural Education and Development Society (READS) Annamalai Nagar, Dharmaraja Koil Street, Chetpet (Polur), Tiruvannamalai – 606 801.	Tiruvannamalai Dt.	Tiruvannamalai and Surrouding areas
10	Community Health Awareness & Natural Green Environment Society (CHANGES) Near A.U.M.S.NP.G.Center ADB Road, Timmapuram Panchayat, Kakkinada, A.P.Statate – 533 005	Pondicherry Union Territory	Yenam conclave

APAC Partners- WIP Project

1	Community Health Education Society (CHES) Kodambakkam, Chennai - 600 024.	Chennai Dt.	Chennai South and Chennai Central
2	Teddy Trust, Tirumangalam Madurai - 625706	Madurai Dt.	Madurai South
3	Anbalayam, Subramaniapuram, Tiruchirapalli - 620620	Tiruchirapalli Dt.	Tiruchirapalli Town Srirangam
4	Center for Social Reconstruction, Nagercoil	Kanyakumari Dt.	Nagercoil & Kanyakumari surroundings
5	Association for Integrated Rural Development (AIRD) Valliyoor Tirunelveli – 627 117	Tirunelveli Dt.	Tirunelveli Corporation area
6	Tamilnadu Rural Environment ECO Development Organisation (Tree) Sivakasi, Virudhunagar Dt.	Virudhunagar Dt.	Sivakasi, Rajapalayam, Virudhunagar
7	Seva Nilayam Society, Rajathani Post, Aundipatti, Theni Dist - 625 512,	Theni Dt.	Aundipatti, Theni Sourounding areas
8	Society for Development Research & Training (SFDRT), Pondicherry – 605 001	Pondicherry Union Territory	Pondicherry town and surroundings.

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APAC Partners - PATH Project

1	Khajamalaia Ladies Association (KLA) Vengamedu, Karur-639003	Karur Dist.	Vengamedu, Karur Velayudhampalayam, Pavithram, upto Kodumudi NH: 7 & 67 About 60 kms
2	PACHE TRUST Ponmeni Jayanagar, Madurai - 625010	Madurai & Theni Dt.	Madurai to Theni Madurai to Kottampatti Madurai to Kodai Road N.H. 7 & 49 - About 72 Kms
3	Alternative for India Development (AID) Kattupakkam, Chennai - 600 056.	Kancheepuram Dt.	Poonamallee to Sunguvarchatram NH 4 about 60 kms.
4	PRAKRITI Santhi Nagar, Hosur - 635 109	Krishnagiri Dt	Hosur Bus stand to Royakotta and Krishnagiri NH 46 about 40 k.ms.
5	Association for Rural Mass India (ARM) Gandhi Nagar, Villupuram - 605602	Villupuram Dt.	Vikravandi, Villupuram Koliyanur to Ulundurpet NH 45 about 60 kms
6	GRAMALAYA Thillainagar Tiruchirapalli - 620 018	Tiruchirapalli Dt.	Chennai Trichirapalli High way from Perambalur to Manaparai including Vralimalai NH - 45 about 60 kms
7	Victoria Educational and Social Welfare Trust Jayasree Nagar, Coimbatore - 641005	Coimbatore Dt.	Chenniampalayam, Ukkadam, Kuniamuthur Madukkarai, K.K.Chavadi, Nilambur, Mudalipalayam piruvu, Ettimadai, Walayar Velamthavalam, NH- 47 about 60 Kms.
8	Santhoshi Social Science Research & Welfare Center Valasaravakkam, Chennai 600 087	Tiruvellore Dt.	Puzhal, Redhills, Padianallur, Sholavaram Karanodai Bridge, Thachur NH - 5 about 45 Kms.
9	Rural Integrated Development Organisation (RIDO), Morappur, . Dharmapuri - 635 305	Dharmapuri Dt.	Kaveripattinam to Salem NH - 7 about 120 Kms.
10	Women's Orgn in Rural Development (WORD) Pallipalayam Namakkal – 638 006	Namakkal Dt.	Namakkal Town An area of about 10 sq.kms
11	Hope Foundation Tambaram, Chennai – 600 090	Kancheepuram Dt.	Tambaram, Mamundur Padalam NH - 45 About 60 Kms.

APAC Partners - Care & Support Projects

1	Bethesda Hospital, Ambur, Vellore Dt. – 635802.	Vellore Dt	Vaniyambadi Tk
2	Mahatma Gandhi Elaignar Narpani Mandram, Rasipuram Namakkal Dist637 408.	Namakkal	Namakkal and Puduchatram blocks.
3	Russ Foundation Ellis Nagar Madurai – 625010	Madurai Dt.	Madurai West and Alanganallur blocks
4	Public Welfare & Dev. Society (PWDS) Gobichettipalayam Erode Dt.	Erode Dt.	Gobichettipalayam and Bhavani blocks.
5	Society for Serving Humanity, (SSH) Madurai Road, Sempatti, Dindigul Dt 624707	Dindigul Dt.	Dindigul and Sembatti blocks.

USAID/ FHI Partners- Comprehensive prevention, care and support projects

S.No	Name of NGO/Govt	Geographical coverage	Type of intervention
1.	Community Health Education Society (CHES)	30 slums in Chennai city	OVC
2.	Sahai Trust	Central Chennai and South Chennai	IDUs
3.	Sahodaran	40 cruising sites of Chennai city	MSM
4.	INP+	Country	Capacity development of PLHA networks
5.	Women's Organisation for Rural Development (WORD)	Namakkal Taluk	OVC
6.	INP+/HUNS	Namakkal, Rasipuram, Tiruchengodu and Paramathy Vellore	Positive living- HIV prevention, Care and support services
7	PCI/YWCA	Salem	OVC
7.	Arumbugal Trust	Manoor,Ambasamudram,	Comprehensive
8.	Peace Trust	Kadayam ,Pappakudi	prevention ,care and
9.	Aussi Codes	Blocks	support- SHG,OVC,
10.	Center for People Education (CPE)	Palayamkottai&Tirunelveli Town	migrants and Community VCT
11.	TANSACS/District Collector – DAAC- Multisectoral District Action Planning (DAP)	Namakkal	TA to TANSACS/District Collector on Multisectoral DAP development
12	TANSACS/District Collector – DAAC- Multisectoral District Action Planning (DAP)	Tirunelveli	TA to TANSACS/District Collector on Multisectoral DAP development
13	TANSACS/District Collector – DAAC- Multisectoral District Action Planning (DAP)	Theni	TA to TANSACS/District Collector on Multisectoral DAP development
14	TANSACS-Tamilnadu State Multisectoral HIV/AIDS Program Implementation Planning (PIP)	Tamil Nadu	TA to TANSACS & USAID/Futures Group for Tamil Nadu State PIP development

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PWDS Alliance Partners in Care and support

1.	AIRD	Ramnad	Mandapam, Thiruppulani, Ramanathapuram Municipality
2.	AIRD	Tirunelveli	Valliyoor, Nanguneri
3.	Arulagam	Dindigul	Reddiarchatram
4.	Blossom	Virudhunagar	Virudhunagar, Sivakasi
5.	CAST	Tirunelveli	Kalakad
6.	СВН	Kanyakumari	Thiruvattar, Thuckalay
7.	Chevaliar	Tuticorin	Thoothukudi, Kayathar, Kovilpatti
8.	CSR	Kanyakumari	Melpuram, Munchirai
9.	PACHE Trust	Madurai	Kottampatti, Melur
10.	RED	Tirunelveli	Radhapuram, Nanguneri
11.	SEDCO	Tuticorin	Alwarthirunagari, Sattankulam, Udankudi
12.	Sevanilayam	Theni	Aundipatti, Periakulam, Cumbam
13.	SRDPE	Theni	Theni
14.	Anbalyam	Trichy	Manachanallur, Thiruverambur, Trichy
15.	CARE	Erode	Erode, Bhavani, Perunthurai
16.	Gramium	Karur	Karur Municipality, Kulithalai, Krishnarayapuram
17.	Imayam	Coimbatore	Coimbatore Corporation, Thondamuthoor
18.	NMCT	Coimbatore	Periyanaickenpalayam, Kaundampalayam Municipality, Karamadai
19.	SSH	Dindigul	Athoor, Nilakottai
20.	WORD	Namakkal	Pallipalayam

TAI Partners

1.	ARM	Chennai	Anna nagar, Porur & Poonamalle
2.	CHES		Koyambedu, Kasimedu & Tolgate
3.	DESH		Kasimedu, Tolgate
4.	ICWO		Anna nagar, Porur & Poonamalle
5.	WORD	Namakkal/karur	Namakkal dt
6.	MSDS	Trichy/Thanjavur	Triverumbur, Tanjore & Kumbakonam
7.	PCI	Salem	Omalur, Valapadi, Kitchipalayam
8.	PDI		Salem bus st. Municipal limit, Ammapet
9.	VRDP		Salem bus st. Municipal limit, Ammapet
10.	ARCOD	Krishnagiri	Krishnagiri, Bargur, Mathur, Kelamangalam & Thally
11.	PRAKRITHI		Hosur, Shoolagiri, Veppanapalli, Kaveripattinam
12.	RIDS	Dharmapuri	Panjappali, Vellichadai, Marandahalli, Palacode, Karimangalam, Morappur
13.	RIDO	Dharmapuri	Dharmapuri bus st. A.kottai, Nallampalli, Thoppur, Bommidi, Pappireddipatti
14.	CARE	Erode	Erode, Bhavani, Perundurai
15.	SOURCE	Madurai	Anna nagar
16.	MAHASEMEAM		Alanganallur
17.	PACHE	Madurai	Pudur, Melur
18.	RUSS		Sellur
19.	ISM		Madurai dt
20.	AROGYAAGAM	Theni	Theni dt
21.	IMAYAM	Coimbatore	Coimbatore dt
22.	NMCT	Dindiant	Coimbatore dt
23.	READ	Dindigul	Dindigul, Palani



RGANIZATIONAL EVELOPMENT IN RESPONSE TO HIV/AIDS EPIDEMIC

Dr. P. Krishnamurthy - Dr. Praneeta Varma

he advent of HIV in India was confirmed with the documentation of the first case detected in Chennai in 1986. This discovery triggered a plethora of activities in many spheres including medical and structural primarily intended towards gearing systems to deal with the new threat to public health.

Ever since, the government, along with a host of non-governmental organizations and the positive people has worked in multiple ways to deal with HIV/AIDS. This document describes how these institutions responded to the pandemic during the initial stages of the discovery of the epidemic in Tamil Nadu. This write up consists of three sections, the governmental response, the non-governmental organizations' response and the positive peoples' response. The discussion is based on personal interviews with people who were involved during the infancy stages of the disease in Tamil Nadu and secondary data such as reports, organizational documentation, and other archival material. Despite efforts to capture the exact institutional response, there were some limitations such as lack of systematic documentation, which made us rely heavily on the memories of those involved in the process, making it difficult to get figures to substantiate the statements. However, this write up is an attempt to capture the spirit of the response to HIV/AIDS.

Genesis

1986	HIV Case reported in India in Tamil Nadu Government General Hospital, Madras & Christian Medical College Hospital, Vellore began documenting data on HIV/AIDS. National AIDS Committee setup.
1987	National AIDS Control Program set up
1989	Medium Term Plan in place
1992	National AIDS Control Organisation established
1992-99	National AIDS Control Program Phase-I
1992	State AIDS Cell formed in Tamil Nadu with World Bank/ NACO funds.
1993	YRG CARE, CAN, TNVHA, SIAAP and other NGOs actively participated in HIV prevention and control efforts in the state.
1994	AIDS Cell converted to Tamil Nadu State AIDS Control Society
1995	USAID funded APAC Project commences. Targeted interventions initiated.
1996	District AIDS Advisory Committee (DAAC) formed.
1997	Pilot Project on Continuum of Care. Mandatory screening at blood banks introduced. PLHA Networks were formed. Registration of INP+ in Tamil Nadu.
1998	Registration of PWN +.
1999-04	National AIDS Control Program Phase II
2000	TI programs for MARP expanded to rural areas
2001	Chennai Corporation AIDS Prevention and Control Society (CAPACS) started functioning.
2002	FHI funded projects for OVC and capacity building of INP+ and Positive Living Project at Namakkal
2003	Bill and Melinda Gate foundation supported Tamil Nadu AIDS Initiative (TAI) was formed and care and support initiatives of PWDS Alliance
	Consortium of partners working in Tamil Nadu was formed under the aegis of TANSACS.

In 1986, little was known to India about the disease's manifestation, diagnosis, prognosis, modes and methods of transmission. In Chennai, MMCH initiated a surveillance to understand the epidemic. A ten-bedded separate ward to provide in-patient care was set-up in the same hospital, while CMC Vellore decided to integrate HIV care into all their services. The AIDS Cell team leader Dr Radhakrishnan, mentions that all that was known about HIV then was that, it was sexually transmitted and considered, "an immoral disease that exposed people to societal stigmatization".

With fear and denial cutting across all sectors from policy makers to the health professionals there was an uphill task ahead for all those who were involved in combating HIV/AIDS. Dr Krishnamurthy recalled, "the nurses and doctors and ward attendants would not go near them, they would slide the food and toss their tablets out of fear, then we had to touch the patients and explain that it does not spread like that". The response to the disease began confronting the uninformed attitudes of the health professionals and the general public. Given this context of limited awareness and low capacity

ORGANIZATIONAL DEVELOPMENT IN RESPONSE TO HIV/AIDS EPIDEMIC

to deal with the huge pandemic the government with the help of the international/bilateral agencies embarked on a multi level response. Based on the recommendations of the National AIDS committee, the Government of India set up the National AIDS Control Program in 1987. This Program in consultation with the WHO developed a Medium term plan for AIDS control in 1989. The first National AIDS Control Project (NACP 1) was launched in September 1992 till September 1999 and was further extended up to March 1999.

NACP II was planned for the period of 1999 to 2004 and further extended to March 2006. The Project works on collaborative funding from the Government of India (GoI), USAID and DIFID. The NACP-II was implemented in 35 states/UTs and 3 municipal corporations namely Ahmedabad, Chennai and Mumbai through the AIDS control societies.

NATIONAL LEVEL: ORGANISATIONAL STRUCTURE

In 1986, under the Chairmanship of the Ministry of Health and Family Welfare, a National AIDS Committee (NAC) was constituted. The Committee had representatives from various sectors and the mandate for the committee was to develop strategies and implementation plans for prevention and control of HIV/AIDS in the country.

The Gol established the NACO in 1992. NACO functioned as an executive body in the Ministry of Health and Family Welfare [MoHFW] at New Delhi to coordinate the prevention and control of AIDS in the country. NACO is headed by an Additional Secretary as its Project Director who is assisted by an Additional Project Director (Technical), five subject specialists and forty-seven other technical and administrative staff.

Under the chairmanship of Secretary (Health), MoHFW a NACB was constituted which reviews the policies laid down by NACO, grants sanctions to various projects, undertakes procurement and awards contracts to private agencies. The Board also approves annual operational plan budgets, reallocates funds between program components, forms project management teams and appoints senior program staff. The Board exercises all financial and administrative powers which are beyond the powers of the Project Director, NACO and which only the Department of Health, Government of India, can exercise with the approval of the Department of Expenditure, Ministry of Finance. No separate reference to the Ministry of Finance for funding of planned activities is required as the Ministry of Finance is represented on the Board.

STATE LEVEL: ORGANISATIONAL STRUCTURE

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

Government's Response to HIV/AIDS:TAMILNADU

The Tamil Nadu State AIDS Project Cell (SAC) was set up in 1992 as part of the NACP Government of Tamil Nadu initiated the AIDS Control program as recommended by the medium term plan of Government of India. This was created as a project, administratively under the DME. Its early activities centered on strengthening blood banks with required equipment and testing kits for HIV and Hepatitis-B and preventing STDs and spreading mass awareness about HIV.

The SAC was headed by a Project Leader a senior doctor of the Directorate of Medical Education who was supported by two other medical professionals for STD control efforts, epidemiology and training. The Project Leader was the team manager for the AIDS control program and responsible for program management, blood safety, administration, supervision and monitoring of the program activities. Joint Director was responsible for IEC, social mobilization and disease surveillance. The Project Officer was responsible for STD control and condom promotion.

AIDS Cell prioritized its activities on:

- 1. Creating Awareness
- 2. Blood transfusion & safety
- 3. Prevention of STD, HIV and condom promotion

Dr. Kantharaj, the then Project Officer responsible for STD control and condom promotion recalls, "In the initial days there was a lot of support from WHO, frequent visits by technical experts helped us in setting up the AIDS Cell". A study to understand the link of STD and HIV was carried out. AIDS Cell brought in some NGOs that were working in the state, convincing them on their roles and responsibilities and initial partnership in this endeavor was with SIAAP, CAN, TNVHA, ARFI, Teddy Trust, CHES, DESH, YRG among others. Workshops to develop IEC materials were conducted and awareness campaigns were launched in the state.

Strengthening the screening at blood banks was one of the areas emphasized during the early days of the HIV/AIDS program in Tamil Nadu. Dr Radhakrishnan recollected that, "initiating the process of regularization, implementing the licensing for blood banks were one of the first accomplishments".

In 1993-94 there were 149 blood banks (Govt.-88; Pvt-61) of which 85 were licensed (Report of State AIDS Project 1993-94). From 1989, in a phased manner volunteerism in blood donation was encouraged and by 1996 mandatory testing was in place in blood banks.

Being the first Project Leader, heading the AIDS Cell in Tamil Nadu, Dr Radhakrishnan recalls the initial confusion as to how to approach an epidemic that had multiple dimensions and required quick decisions and actions, "NACO had sent on equipments and we were given this one small room where all the things were crammed up. The team had Dr Krishnamurthy, in charge of Epidemiology and Training and Dr Kantha Raj, in charge of STD control. Secretarial staff had to be accessed from the secretariat and even office assistants were posted after considerable time". One of the steps forward was the allocation of the building that now houses TANSACS office, to the AIDS Cell. This building was earmarked for central blood bank, but with consistent efforts and persuasion it was allocated to AIDS Cell.

Commissioner and Secretary to Government Health and Family Welfare Department Government of Tamil Nadu Directorate Of Drugs **Directorate Of Medical** Directorate Of Public control Directorate of Education Health and Preventive Directorate Of Indian Medicine Medicine Medical and Rural system Health services STATE AIDS CELL TECHNICAL STAFF Project leader (Additional Director of ADMINISTRATIVE STAFF Medical Education), Administrative officer - 1 Statistical assistant - 1 Joint Director (BS) Superintendent - 1 Project Officer (Deputy Director of Medical Accountant - 1 Computer programmer - 1 Education) Assistant - 1 NGO advisor Typist – 1 Driver - 1 District Level AIDS advisory committee District collector - Chairman Dean/Joint Director of Health services (Convener) District social welfare officer District mass education officer STD specialist Blood bank medical officer Microbiologist Medical specialist Obstetrics and gynecology specialist

Figure 13: ORGANOGRAM OF AIDS CELL

The complex system of approval for activities and funds considerably slowed down the process for efficient functioning of the AIDS Cell. Under this system DME and DMS clearance was required for each activity. Approval for every financial decision had to be obtained from the state govt., which considerably slowed down the pace of activities. One of the reasons observed for the shift from AIDS Cell to a society model was the under utilization of the funds allotted by NACO for the state. This led to a new dimension in the administrative structure. A more flexible and manageable structure was envisioned leading to the formation of the TANSACS.

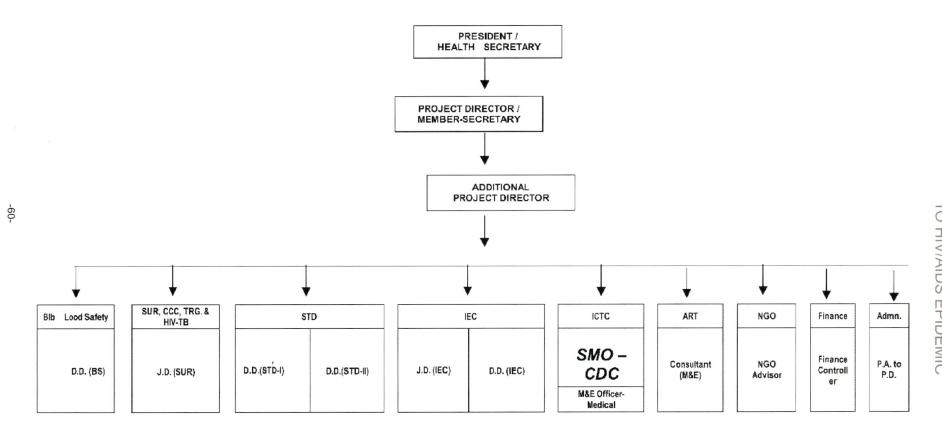
Conversion of the State AIDS Cell into a Registered Society: Tamil Nadu State AIDS Control Society, May 1994.

When HIV was first detected in the state, the only public health program, which looked at sexuality, was the Family Planning Program. But the AIDS scenario was very unlike Family Planning. Decisions and consequently actions had to be taken faster. The experience from Family Planning program showed that the data systems were poor and money matters took a long time in processing. The early experience of AIDS cell was not very encouraging. Therefore, it was seriously felt that a change was required in the administrational set-up of the AIDS cell, which was started in response to the new challenge. So for both reasons financial expediency and quicker program response, a society model was suggested. This model would do away with unnecessary protocol and the funds would flow directly to the Society without involving the state govt. The inspiration for this model was the District Rural Development Agency (DRDA) model that was being successfully implemented at the district level with the District Collector as president of the registered society and funds moving directly from the Centre to the Collector. The National Literacy Program had also tasted success as a society model. The lessons learnt from this campaign were the advantage of administrative ease, transparent fund flow and flexibility in functioning. Subsequently based on World Bank evaluation report, NACP Phase II adopted this for other states for the second phase.

TANSACS was set up as an autonomous society in 1994. The Health Secretary of the TN State Government, a senior civil servant of the Indian Administrative Service (IAS) is the President of the TANSACS. Another IAS officer is the Project Director and Member-Secretary. TANSACS established an Executive Committee (EC) which has administrative and financial powers to ensure prompt and effective implementation of AIDS control activities in Tamil Nadu. Other members in the committee include: Secretaries of Government Departments like Finance, Education, Social Welfare and Planning as well as the heads of the various Health and Medical Directorates as well as representatives from NGOs and PLHA.

Full financial powers were delegated to its EC, which has the Finance Secretary or his/her representative as its member to facilitate quicker approval of proposals and the release of funds and faster utilization of funds by TANSACS. Due to this better utilization of funds, NACO allotted unspent funds from other states to TANSACS, especially during 1996-99, thereby making more funds available for HIV control efforts in TN. The autonomous SACS model of Tamil Nadu was considered a success and replicated across the other states. With the formation of such societies in other states, post 1999, the utilization of funds improved all over India, resulting in a decline in the funds allotted to TN.

Figure 14: ORGANOGRAM- TANSACS



Source: TANSACS

ACTIVITIES

In the first phase of NACP, the thrust was on awareness generation in the community, blood safety, STD control and promotion of condoms. As the epidemic progressed in the state, the government initiated a diverse range of activities to meet emerging needs of the population. The infrastructure facilities to deliver these services were created in accordance with the requirements.

The major areas of activity of TANSACS were awareness campaigns, targeted interventions among high-risk groups through NGOs, blood safety, STD control, and the care and support of people affected by HIV/AIDS (TANSACS Report, 1998).

As part of the NACP II guidelines, Targeted Interventions were introduced, therefore, systems to fund and select NGOs was set up.

Targeted Interventions: In 1994-1995, 17 NGOs were selected to implement the intervention programs, of which 4 were involved in targeted interventions (TI) and 13 were involved in mass awareness programs. Over the years NGOs involved in mass awareness programs were reduced and specific targeted intervention programs were encouraged. In 2004, TANSACS supports 61 NGOs in implementing targeted interventions across the state with 378 individuals directly involved in program delivery.

STD Services: In 1993 there were 50 STD clinics functioning of which 37 were clinics attached to the district HQ hospitals, 9 in medical colleges and 4 in vigilance homes. In 2004, over 100 STD clinics are functioning in all Medical colleges, district hospitals and some of the taluk head quarters hospitals. TANSACS supports Drugs, Consumables, Equipments and funds for infrastructure. The drugs are provided though Tamil Nadu Medical Services Corporation. The Government of Tamil Nadu runs the centers with the support of TANSACS.

HIV Testing: Voluntary Counseling and Testing Centers (VCTC) were set up in Tamil Nadu with a view to facilitate early entry into the continuum of care. In1999-2000 TANSACS set up 3 VCTCs and gradually expanded to 110 VCTC facilities by 2004-05 (Ref: Table 4). A team consisting of a trained medical officer, a counselor and a lab technician are present at these centers. The state government posts and pays the medical officer while TANSACS pays the counselor and lab technician through a nodal agency [SIAAP] identified to provide technical and monitoring support for VCTC.

Table 5: VCTC EXPANSION: YEAR-WISE DATA.

YEAR	NUMBER	
1999 – 2000	3	
2000 - 2001	11	
2001 - 2002	23	
2002 - 2003	5	
2003 - 2004	68	
TOTAL	110	

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Prevention of Parent to child transmission of HIV: Initially 3 Centers of Excellence in Chennai providing PPTCT services were set up along NACO guidelines. At present (2004), 149 PPTCT Centers are functioning all over the state placed in both government and private institutions. Each PPTCT center has a team consisting of an Obstetrician, a Pediatrician, a Microbiologist, a Counselor, a Lab technician and staff nurse. UNICEF and GFATM partner with TANSACS to provide this service comprehensively in the state. SIAAP is also involved in training and supervising the counseling services.

Blood safety: There are 79 blood banks in govt. sector and 123 blood banks in quasi-governmental, voluntary and private sectors. Each blood bank has a team of specially trained Medical Officer, Lab Technician, Staff Nurse and Office Assistant. In blood banks situated within medical colleges, counselors are also provided. TANSACS supports salary for lab technician, test kits, reagents, consumables and essential equipments to all government blood banks. Currently all blood specimens are routinely screened for HIV, HCV, Hepatitis B, VDRL and Malaria.

District AIDS Advisory Committee (DAAC)

Government of Tamil Nadu realized the importance of creating a decentralized set-up and formed District AIDS Advisory Committees in 1996, with representation from different sectors. The DAAC functions under the Chairmanship of District Collector, to plan, implement and coordinate the HIV/AIDS related activities in the district. Multi-sectoral approach, and decentralized planning are the key concepts of this committee. However a lack of clear guidelines and monitoring systems hampered effective functioning of DAAC.

District AIDS Advisory Committee Chairman / District Collector Member Secretary/ Joint Director, Health Services Nodal Officer Member **District Mass** Deputy From Special Director. Different Departments Invitees Education & Health Professional bodies Information Officer NGOs & CBOs & District Extension Services (HQ) Associations Educator

Figure 15: ORGANOGRAM OF DAAC

Care & Support

Organization Structure in the early phase: Primarily medical colleges in the state took a lead. Madras Medical College (MMC) and Christian Medical College (CMC) at Vellore represent the pioneer institutions in government and non-governmental sector, which rose to the occasion and showed direction through innovative thinking. WHO facilitated this early response through Indian Council of Medical Research. The two institutions took different approaches to the HIV epidemic.

The Govt. General Hospital, Fort area, Chennai created a separate 10-bed ward managed by Dr. Jayakar Paul and Dr. J. R. Sankaran for providing institutional care to people living with HIV was started at Govt. General Hospital. Later this facility was shifted to Government Hospital of Thoracic Medicine in Tambaram given the relatively high numbers in co infection of HIV and Tuberculosis. CMC, Vellore on the other hand integrated care for PLHA within the routine care in the regular medical wards. The development of Thambaram Center in Chennai and the integrated approach at CMC reflect the advantages and disadvantages of both the systems in the care of PLHA in the state and provided important learning experience.

The Government Hospital for Thoracic Medicine (GHTM)

GHTM in Tambaram started in 1928. In 1937 Government of Madras introduced in-patient services for the growing number of tuberculosis patients. This hospital is a haven not only for TB patients but also for HIV/AIDS patients. Special wards have been set up for HIV/AIDS patients who are given treatment for various opportunistic infections by a dedicated team of doctors. The hospital has also conducted trials for Siddha drugs for HIV/AIDS. Nutrition support is provided for in-patients. The hospital also trains Physicians Responsible for AIDS Management [PRAM] for various other Government hospitals in the State.

The IRT Medical College Perundurai, a quasi-government hospital, was also one of the first few hospitals in the districts of Tamil Nadu to provide institutional care for those infected.

Meenakshi Mission Hospital and Research Centre (MMHRC), a 500 bedded, multi-specialty, non-profit organization has also been offering HIV/AIDS care for a long time now. MMHRC was began functioning in 1990 in Madurai and caters to people from Southern Tamil Nadu.

Currently TANSACS extends financial support for the purchase of drugs to manage opportunistic infections and post-exposure prophylaxis. TANSACS supports 13 private institutional care centers, 5 community centers and 8 drop-in centers. As the epidemic progressed, the magnitude of the problem became evident and the state and the Central Governments up-scaled the organizational structure within and outside the health sector to deal with the epidemic with assistance of bilateral and international partners.

Response from the Non-Government Sector

On one hand, the response from government geared up the public health sector to deal with the epidemic. However, medical attention alone was not the need of the hour. A grass-root approach to

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address the social dimensions of the disease led to a close collaboration between different sectors to scale up the response and put up a united effort to combat the challenge. The non-government organisations emerged as one the key partners and were instrumental for taking the initiatives to specific populations and target communities. The NGO support strengthened the government efforts in the state and this partnership model contributed significantly to the stabilization of the epidemic today. This section presents organizational response of some of the not-for-profit sector organisations which though not exhaustive, is indicative of the changes that NGO activities and structures underwent to respond to the emerging needs of the epidemic.

1. APAC-VHS

The Government of India took up the response to HIV/AIDS prevention in India, as a high priority, in co-ordination with international agencies. Since, Tamil Nadu was identified, as one of the epi-centers of HIV/AIDS, there was a thrust to stop the spread of HIV/AIDS within the state and USAID chose to focus the efforts in Tamil Nadu and Maharashtra, two of the states having a high prevalence of HIV.

VHS is a leading NGO founded by Dr Sanjivi is functioning in the state since 1958. Under the leadership of Dr N.S.Murali, VHS recognized the need to get involved in preventing the spread of the epidemic and also provide care for those infected. Thus came to fruition the APAC VHS project with the primary objective of preventing and controlling the spread of HIV/AIDS through sexual mode. A tripartite agreement was signed between USAID (Donor agency), Government of India NACO and the VHS of Chennai, Tamil Nadu in Feb 1995.

APAC project is overseen by a project management committee [PMC] with the Secretary Health, Government of Tamil Nadu serving as its chairperson. Other members include representatives from the NACO, TNSACS, USAID and VHS. This committee sets the policies and guides APAC. It meets periodically to review proposals and approve grants to NGOs.

A team of professionals forms the core team at APAC secretariat to manage the entire project. APAC is headed by a Project Director to whom a team of Program Managers reports. Each program manager is responsible for one division STI Control & Management, Behavior Change Communication, Condom promotion and Private sector initiatives, NGO & Capacity Building, Care & Support, Research and MIS. Finance, Contracts and administration form a parallel division under the PD.

Table 6: Staff Structure of APAC - VHS

Staff structure	1997	2005
Professional staff	8	9
Support staff	6	11
Attendant	2	4
Technical experts	0	2

Initially space was provided in VHS teaching department, but later one floor in the administrative block was provided for setting up APAC secretariat. Gradually as the program expanded, another floor to house training room, work-space for consultants, board room and other staff etc. was added.

Ms Sandhya, Senior Program Support Officer, was one of the earliest to join the projects recalls the excitement when the first fax machine and two black and white computers were bought in 1995-96. Today each staff has a personal computer- Internet and LAN supported. Each of APAC projects also have been provided similar facilities and internet driven monitoring systems were introduced since 2003-04.

The focus of the APAC project is to check the sexual transmission of HIV and provide community based care for PLHA. Targeted Interventions [TI] among high-risk population were initiated in the state in certain geographical locations based on mapping of high-risk populations/ vulnerability factors. 48 towns across 18 districts were identified to have a higher density of factors that enhanced vulnerability to HIV.

In 1997, APAC launched the first TI projects in partnership with two NGOs PACHE, Madurai & MSDS, Dindigul. This intervention- PATH- Prevention along the Highways focused on truckers and paved the way for other projects addressing the same population [thematic interventions] in eleven locations identified along the highway as priority interventions sites being major halting points of trucks.

In 1998, APAC-VHS added three new themes in addition to PATH, being:

- Women in Prostitution (WIP)-6 interventions were initiated
- Slum Intervention Program (SIP) 8 interventions were initiated
- Tourist & Women Intervention Program (TWIP) 6 interventions were initiated

Table 7: NGO PARTNERS TARGETED INTERVENTION PROGRAMS - 2005

Sl.No.	Theme	No. of NGO Partners
1	Prevention Along The Highway [PATH]	13
2	Tourist & Women In Prostitution [TWIP]	10
3	Slum Intervention Project [SIP]	10
4	Women In Prostitution [WIP]	8
5	Industrial Intervention Project [IIP]	9
6	Men Having Sex with Men [MSM]	1
7	Care & Support [C&S]	5
8	Intervention among Migrants	2
	Total	58

Each TI project has a team of Project coordinator, counselor, social workers and computer operator cum accountant. The office is equipped to facilitate activities and computer with internet connection, slide projector/audio-visual systems are available at the sites. The project team identifies and trains non-paid peer educators to take messages forward in the community.

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Activities & Structural response:

Prevention and Control of Sexually Transmitted Diseases [STDs]: APAC has developed a comprehensive model of STD care for high-risk groups that combines the use of innovative behavior change strategies to raise the demand for quality STD services and training programs for the Health Care providers [HCPs] to meet this demand. The NGOs build referral linkages for STD care with HCPs in their areas and also refer on the health care providers for appropriate training.

Five Continuing Education and Training Centers [CETC] are currently providing training to Health Care providers (Allopathic practitioners, Indigenous practitioners, Pharmacists, Community Health Workers and ANMs) on quality care for STD patients. Nearly 16,000 health care providers have been oriented to HIV/AIDS in the state.

Table 8: No. of Personals being trained in the Continuing Education and Training Centers

HCP Category	Male	Female	Total
Allopathic Practitioners	2609	1349	3958
Registered Indigenous	3514	558	4072
Medical Practitioners			
Pharmacists	3021	235	3256
Community Health Workers	636	2601	3237
Auxiliary Nurses &	45	1387	1432
Midwives			
Total	9825	6130	15955

STD treatment was available only in the government hospitals and in some private clinics. In 1998, in an attempt to improve the access to quality STD services APAC introduced STD Clinic Interventions Project and an integrated STD/MCH/FW intervention in an attempt to integrate STD services with MCH clinics to facilitate access by women.

BCC

T.I. programs rely on mass media and interpersonal communication to bring about changes in behaviour- awareness regarding HIV/STI, health seeking behavior, adoption of safer sex practices, risk perception, HIV testing and stigma reduction. APAC empanels leading advertising agencies through a competitive bid process. In accordance to the need/focus for communication, supportive media and messages are developed by the empanelled agencies. One officer at APAC is responsible for managing the BCC activities. APAC supports three Resource & Training Centers to train project staff in using traditional media.

Condom Promotion

To improve availability of condoms in TI areas, APAC has established partnerships with condom manufacturers in the state HLL, TTK, JKaL. TI staff and peer-educators identify non-traditional outlets in their area to retail condoms and given the taboo that surrounds stocking condoms, the retailers first undergo a sensitization program conducted by NIS-SPARTA, an agency retained for

this purpose by APAC. Center for Entrepreneur Development has been contracted to train NGO staff in social marketing for condoms. At APAC one officer is assigned to look after condom promotion activities and private-sector collaborations.

Capacity Building:

Building skills of all involved in program delivery is one of the thrust areas of APAC. Across the state APAC collaborated with leading institutions to provide training for the project personnel. Training modules were developed in consultation with program specialists, technical experts, etc. Training organizations and NGOs are drawn from the country. One of the first organizations APAC enetered into contract with was YRG CARE.

Other organizations that APAC partners with to develop the skills of staff and peer educators include CMC, SIAAP, CCOORR, TNVHA, MMHRC, PSG Institute etc. Peer educators in the earlier days of the program were trained by GIRH, Gandhigram but as capacities were developed, some of APAC partners NGOs were identified as training centers for peer educators for specific themes.

For providing experiential experience on TI, demonstration centers for each theme WIP, SIP, PATH have been established. Besides new NGOs that join APAC project in implementing interventions, SACS from other states also send on their partners for training here.

Care & Support

Five NGOs are involved in delivering community based care to PLHA in specific locations. VCTC are recognized as the entry point to the continuum of care services and given the accessibility issues, APAC set up VCTC in intervention areas in NGO settings. Each VCTC has a lab technician, counselor and medical officer available. VCTC are also set up in partnership with private facilities. Capacity building of committed HCP involved in providing clinical management of HIV is done in partnership with MGR medical university.

2. SIAAP:

SIAAP started functioning from a small room at the VHS annex. This small space with a computer, was provided by Ms. Shyamala for the office. In 1992, SIAAP shifted to a 1300 sq.ft space in Kamaraj Avenue 1st street where it continued to function until 2004. As the staff members started increasing after 1997, there has been considerable development in the infrastructure. By 2000, SIAAP hired an independent building with 2 floors and 3000 sq.ft of built-in space for its training purposes. It provided a training hall, accommodation facilities for the trainees and was also easily accessible as it was located opposite the Guindy Railway Station. By 2001, in order to ensure enough workspace, interior work was done in the office to create work stations and storage for individual staff. By 2003 the training centre was shifted from Guindy to Balaram Street, Adyar which made it easier to manage, as the office and training centre were very close to each other. By the end of 2003, it started looking for a bigger space to give a quality work environment and it identified and contracted the new office in 2004 at the 2500 sq.ft space 1st floor building at Jeevanandam Street, where its functioning now. By early 2004, SIAAP closed its training centre as the cost of maintaining became too high. By September 2004, the office was shifted to the new building with an aesthetically pleasing interior and individual workspace for all staff.

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SIAAP Staff: At the inception period of SIAAP, there were around 5 paid staff and the Founder and Director, Ms. Shyamala Natraj, worked on a full-time volunteer basis.

During the period 1992-1996 there were 3 office staff taking care of office administration, 2 program staff for the truckers project and 15 field staff for the sex workers program. The Director continued to volunteer. There were a few volunteers for the hotline program that worked for 12 hours every day.

The phase of 1996-97, could be called the SIAAP burnout stage where the management felt it was time to close down for a much-needed period of rest and reflection. At this point there were 3 paid staff and a few volunteers who continued to provide their services for SIAAP.

During the period 1996-2000, the counseling team was strengthened with 7 members including 2 trainers. There were around 10 staff for administration and finance. There were 30 counsellors working under the pay-role of SIAAP.70 peer staff were paid through SIAAP who worked in different districts and also bridged the needs of community members with the services in the hospital STD departments.

During 2000-2004 there was a marked development in the organisation's capacity. The different departments emerged after the process of restructuring. Each department had a head who took independent charge of their respective projects and sought out the director's guidance wherever needed. The director was heading the Advocacy and the OD departments. There were 10 staff in OD, 8 staff for COMOs, 5 staff for Advocacy and 6 staff working for the counselling department. At present the Organisation has 26 full time staff, one part time staff, 2 trainer consultants and one organisational development consultant.

Contribution of SIAAP for the HIV/AIDS initiatives:

During the period 1992 1996 SIAAP assisted nearly 50 NGOs working with communities vulnerable to HIV to integrate interventions with their existing programs. SIAAP offered training, supervision, networking, advocacy and financial support. Through this, a long-term support network was created which, according to SIAAP, is the obvious method for effective change. SIAAP worked with NGOs intensively to incorporate HIV support, care, education and prevention programs. In the states of Karnataka, Andhra Pradesh and Karnataka, SIAAP helped set up 60 programs covering over 100,000 people in each state.

During the period 1997 2000 the counseling training program and supervisory program has helped over 200 counsellors provide services at nearly 100 district Government hospitals in Tamil Nadu, Andhra Pradesh, Karnataka and Goa. These counsellors worked in STI clinics at Government hospitals in the outpatient wards, and in the field in the afternoon. This approach dramatically increased the safe sex and STI services in rural areas.

Another decisive step included the support and capacity-building of community-based organizations to complement the NGO's efforts. As a preliminary step, SIAAP helped register 20 functional community organizations in Tamil Nadu, comprised of women in prostitution, gay/bisexual men, people with HIV and AIDS, and blind people. These community organizations had a minimal

membership of 25 to 50 members. Thus, around 800 community members were trained in HIV & AIDS prevention, organisation building.

During the period 2000 2004, SIAAP has been entrusted with the training, supervision, and recruitment of counsellors for the VCCTC, PPTCT and Blood Bank counselling programs. By this period SIAAP had appointed 100 counsellors for Tamil Nadu programs and had been disbursing their salaries.

3. Tamil Nadu Voluntary Health Association

TNVHA is an association of voluntary organizations working in the field of community health development with specialty in the areas of networking, capacity building, research, consultancy, publication, information dissemination advocacy etc in Tamil Nadu and Pondicherry. The organization activities were launched from Dindigul where they had their Head Quarters in the year 1970, which was later shifted to Chennai. It was registered under TN Society's Registration Act in 1971. In its 34 years of service, the number of member institutions has grown to 596 which includes hospitals, dispensaries and Community Based Organisations (CBOs)

The organisaton founded in early seventies has started risen up by widening its network particularly in Nineties. The member status in the year 1997-98 was 463 (264 CBO, 103 hospitals and 96 dispensaries) has risen to 635 (448 CBOs, 102 hospitals and 85 dispensaries) in the year 2004.

Their staffing pattern has also gradually changed due to increase in the number of district level and field level staff. This could be comparatively seen in the changing pattern of organograms for the years 1997-98 and 2004-05 (given below)

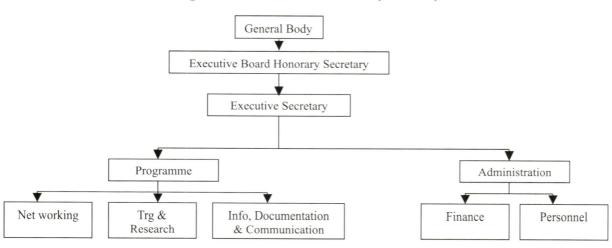


Figure 16: ORGANOGRAM (1997-98)

General Body Executive Board & Sub Committees **Advisory Committee Executive Director** PA to ED Programme Administration Programme Manager -Coordinator Finance & Admin DCC Asst Co-ord Spl Project Coord Communicati on & Support DRC / DSC / DFC / Volunteers

Figure 17: ORGANORGRAM (2004-05)

The objectives of TNVHA include I

- To promote a network of organizations working for health promotion
- To provide a platform for members to come together, share their experiences and work together.
- To build the capacity of members
- To identify issues and pool resources for campaign lobbying and policy advocacy.
- To provide relevant and updated information
- To liaison with government.

Activities

- Networking and coordination District level consultation and follow up program
- Training and Research
- Information, Documentation and communication
- Campaigning, lobbying and advocacy
- Promotion of linkages
- Implementation of special projects.

Administrative Organization / Reorganization State and District Level structures

The TNVHA is able to streamline the district level activities and pave the way for sustaining the same by having similarly corresponding state level and district level structures as given below

State Level	<u>District Level</u>
State General Body	District General body
Executive Board	District Coordination committee
Sub Committees	District facilitation cetres
State secretariat	District resource centre

The agency has also developed systematic techniques for evaluating the performance of individual staff as well as the activities carried out at different levels using appropriate monitoring and evaluation systems.

Funds

The donor agencies for the year 2004-05 are Christian Aid (44%), EJAF (22%0, APAC-VHS (9%) HRIDAY (6%), UNICEF (4%)

Human Resource Development

Generally they recruit staff for various positions by calling newspaper advertisements. Once recruited, the individuals are placed for an "On the Job training" for a period of one months in each cell so as to enable them to know about all the activities of the organization. Later they are placed in the particular component for which they had been recruited. Hence they are adequately trained both in the office as well as in the field.

Capacity Building

Besides imparting training for the NGOs the TNVHA as a part of capacity building process provides various opportunities for the NGOs to initiate, experiment, network and thus enable them to learn and upscale. The issues leased network has really given opportunity for NGSs to build their capacity in many ways as members of District Coordination Committee/ District Resource Centre / District Facilitation Center for different issues.

4. COMMUNITY ACTION NETWORK (CAN)

In the year 1992 -93 a team of three philanthropic people jointly formed a Research Team called CAN which was registered under Societies Act. Initially, the team was involved in an Ethnographic Research activity (pertaining to HIV/AIDS) In association with a WHO Consultant.

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In the beginning, the organization did not have any rigid organizational structure. However, the three members President, Secretary and the Treasurer shared their activities as follows

President

Proposals, planning and implementation of the programs;

Secretary

Field based activities

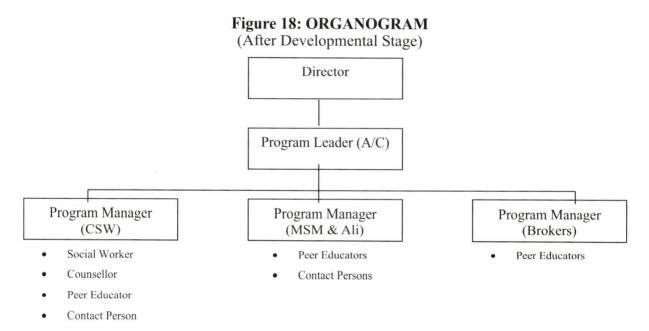
Treasurer

Finance and field based activities

In the year 1993, CAN was involved in awareness programs for HIV. Their activities were later segregated as Sex Worker Component, Brokers component, and I E C Component. Gradually, a full time Doctor was appointed for STI treatment. Besides mass education, group and individual contacts were strengthened by identifying Peer Educators and contact persons among the vulnerable groups. One more Social Worker was appointed to look after intervention with the Broker component. CAN had their offices at two locations one at Villivakkam and another at Virugampakkam.

Administrative Organization/Reorganization

In due course, the organization, with the financial support of WHO Consultant, grew stronger. The organizational structure for this NGO is given below



Later the program extended to more geographical areas (in Chennai) and two more workers were appointed (1994) .The project went on well up to 1997. Target Intervention projects were also included in their activities.

In the mean time, a number of new NGOs had come up and were involved in activities almost equivalent to that of CAN which also did want to duplicate the same work. Moreover, the persons who founded the organization and occupying key positions were able to get better positions in other reputed agencies and as a result, the activities of CAN were gradually ceased.

(The above information was furnished by Ms Uma who was the Treasurer and one of the founders of the organization.)

5. YRG CARE

YRG CARE, founded in 1993, is a non-profit organization which offers education in HIV and sexuality for adolescents and young adults, workplace HIV/STD intervention, voluntary counselling and testing services, HIV out-patient clinic and inpatient services. It is a premier medical and behavioural research centre and offers training for clinicians, nurses, counsellors, educators and laboratory scientists. This centre now provides health care for over 9100 people living with HIV. Its vision is to see that PLHA and their families live with dignity, and there is no new HIV infection, and its mission is to respond to needs of people who are not receiving care and support or education/information about HIV.

Objectives

The overall objectives of YRG CARE are to

- Build awareness of HIV infection and promote safe and responsible behaviour in the community;
- Provide all people access to a non-coercive and non-stigmatized counseling, testing and continuum of care;
- Maintain and develop human resources, physical infra structure and organizational system;
 Advocate for individual rights and policies for a non judgmental, supportive environment for PLHA and people living with this epidemics.

Some of the milestones of YRG CARE since 1993 are highlighted below:

- 1993 Prevention programs for schools, colleges etc./ Voluntary Counselling and Testing Centre established.
- 1994 Clinical Treatment Services were started
- 1995 Continuum of Care Program inaugurated
- 1996 Established VHS-YRG CARE Medical Centre
- 1997 Support Services for PLHA started
- 1998 Networking with other Institutions for formation of Consortium of Consultants / Pediatric Services were started.
- 1999 Family Counselling Centre established / Scale-up project with four partner sites in South India started.
- 2000 VHS-YRG CARE Infectious Diseases laboratory established
- 2001 VHS-YRG CARE Drug Centre set up
- 2002 Learning Resource Center
- 2003 Intensive Care Unit established / Community Research Facility inaugurated at Chetpet/Telecounselling Services inaugurated
- 2004 Nutrition program for Inpatients funded by Andrew Zeigler Foundation commenced
 / YRG Community Outreach Facility CSAR (Centre for Social Advocacy and Research) inaugurated in North Chennai.
- 2005 Global Fund Round II Rollout / Enrollment of participants for clinical trial programs / Commencement of Mother's Project funded by APLA / Yale Public Health and YRG CARE partnership established.
- 2006 YRG CARE-IRCS (Indian Red Cross Society) Nellore Community Clinic established



Set-up of YRG CARE infrastructure:

The organization operates in different places in Chennai with the main Medical Center, Administration and laboratory facilities set up in the VHS Campus. The Community Research Facility is located at Harrington Road in Chetpet, the Community Outreach facility is located in Royapuram, North Chennai. YRG CARE has also extended its Clinical facility (YRG IRCS Community Clinic) at Nellore, Andhra Pradesh.

Funding Agencies:

YRG CARE has extensive clinical trial, behavioural intervention research programs and training that is being supported by international agencies including NIH, WHO, GFATM, USAID and the Ford Foundation among others.

BOARD OF TRUSTEES Y.R.GAITONDE MEDICAL EDUCATIONAL AND RESEARCH FOUNDATION Director Y.R.GAITONDE CENTRE FOR AIDS AND RESEARCH EDUCATION Chief Medical Officer and Project Manager Research Manager Lab Manager/ Clinical Researcher Associate Professor Prevention Services Ethnography & Assessment Medical Officers Training & Capacity building Biochemistry VCT & Follow3-up Hotline - Helpline Transcription Services Serology counseling Information Technology MIS & Data Management Nutrition Microbiology Infrastructure Strategy, Planning Structuring and Quality Participant Enrollment & Clinical Research Immunology & Hematology Retention Documentation & Virology Community Liaison Pharmacy Training Facilitation Molecular Biology Pharmacy Development QA / QC Audits **Biostatistics** Reagent Management Trial Interventions Research Regulatory Issues Client Facilitation Client Services (Behavioral) Management Services Administrative Human Resources, Inventories Administration Phlebotomy Coordinator Insurance. Community Liaison Nursing Bio Specimen Processing Finance & Accounting Clinical Pathology

Figure 19: Organizational Chart

Institutional Profile Form - YRG CARE - Updated Jan 2005

Deepam Educational Society for Health (DESH)

Since 1990 DESH is committed to spread Social Health Education [SHE] and to work for promotion of Reproductive and Child Health [RCH] and prevention/control and care of RTI/STI/HIV/AIDS, improvement of gender equality and empowerment of women.

In the early nineties, DESH started its AIDS control movement in Chennai through counseling services at Government General Hospital. Soon after, DESH began conducting RCH promotion and STI/HIV/AIDS prevention education programs in industries and educational institutions. Utilizing cultural norms that support prevention messages DESH aims at averting incidence of HIV. Focused communication through various channels, particularly using folk media and street theatre to check the spread of HIV/AIDS, DESH believes that by disseminating information/awareness (IA) focusing on empowerment with accountability (EA) will lead to behavior change strengthened and sustained by collective action (CA).

DESH has addressed the community in far-flung areas with effective intervention programs. It encompasses slum areas, hospitals, Female CSWs/clients, mobile populations in organized sector and in pilgrim towns, and in very large numbers at schools and colleges. DESH has shown far-reaching impact in promotion of RCH and prevention of STI/HIV/AIDS, focusing on counseling, care and support. DESH mobilizes formation of action groups facilitating collective movement towards healthy society ensuring sustainability through Group leaders, Community Health Workers (CHWs), Volunteers, Bare-Foot counselors and Self-Help Groups.

DESH has also encouraged women's empowerment through Self Help Groups (SHGs). Counseling services are provided by a trained team of counselors from DESH at the following hospitals and Centres

- Government Hospitals addressing STI/HIV/AIDS for 13 years
 - Government Thoracic Hospital, Chennai the HIV/AIDS/T.B. Cases for 2 years
 - Government Vigilance home and Juvenile home for 2 years
 - On Interactive Voice Response on STI/HIV/AIDS in six major cities

Clinical Services are outreached through DESH's Mobile Clinic Services. Mobile clinical services have treated 8257 RTI/STI cases among men and women at their doorstep Capacity building programs on STI/HIV/AIDS for NGOs; Anganwadi and Balwadi teachers has been conducted over the years. DESH has trained 128 NGOs on Social Health Education to address issues of RTI/STI/HIV/AIDS. 353 Community Health Workers and 17,070 Volunteers have been trained on HIV issues.

The commitment of the organisation to youth issues is evident in their effort to sensitize in-school youth through STI/HIV/AIDS Prevention Education Programs in 2,637 schools, covering 4,09,312 peer educators, students and teachers in six States

Community Health Education Society [CHES]

In 1994 CHES Registered as an NGO under societies act and started to work with children especially AIDS orphans. They started the first HIV care home for HIV infected orphans. By 1995, they were seeing increase in positive sex workers who sought their services and from there their concern included prevention and care for this marginilised community. In 1996, realizing the need to offer non-stigmatized STI care, they set up an STD clinic for high risk population at Chennai with funding support from APAC and in the same year TANSACS supported the NGO to initiate a sex workers intervention program along the sea coastal region in Chennai. In 1997, while continuing with its previous activities, the first Home based care program was initiated as a project by CHES in Chennai with financial support from TANSACS. This project was called Vidiyal. The APAC- VHS-USAID supported WIP intervention project was also started in the same year in Chennai.

CHES assisted the sex workers to register a CBO for them with the objective of taking up routine medical check up and rehabilitation. Counseling services at Government Thoracic Center was taken up by CHES. However their prime concern, being a care providing organisation was also driven by the situation that they were seeing in their shelter home—children infected and affected. In 2000, they received their first fund from Family health International towards a care program for children infected, affected and vulnerable to AIDS. The first 18 months of the project named 'Thooli', focused more on institutional care while in the second phase of this project (18 months) home based and community based care was added along with institutional care. The first manual to train caregivers on care of children was developed. By 2003, CHES supported by FHI, expanded its program for reaching infected/affected children in the high HIV prevalence district of Namakkal in partnership with a local NGO WORD.

From the days when the AIDS Cell was formed to now in 2004 where over 25 agencies are involved in HIV prevention and AIDS care in this state, NGO involvement has improved substantially. NGO Networks were formed in the second phase of the NACP SAATHII had undertaken a mapping of NGOs in the country in 2002-03. In 2003-04 APAC specifically carried out a listing of NGOs working in the state of Tamil Nadu for HIV prevention and care activities and 161 NGOs were mapped.

In 2004, TANSACS initiated a consortium of partners working in the state on HIV/AIDS related issues. Currently there are 25 members in this consortium and this forum provides a space for sharing experiences and planning interventions for HIV in the state in consultation with partners. This minimises duplication of activities and encourages networking efficiently between and across programs.

Networks: People Living with HIV/AIDS

In India, people who have been directly involved with the epidemic, that is, those infected/ affected by the virus, have formed associations to look into their care and needs. Now there are many networks of People Living with HIV/AIDS(PLHAs) throughout the country but the Indian Network of PLHAs (INP+), which is also the first such network, was formed in TN (in 1997) and the secretariat is still based in Chennai. The organization aims to improve the quality of life of people living with HIV in India and exists to provide sense of belonging and togetherness to people living with HIV.

Dominic D'seuza, a youth from Goa was detected to be positive after a routine screening of blood at the Pune Blood Bank. It was in 1989 and the health officials were in Goa were uncertain of what their response should be since earliest cases detected were foreign nationals and were deported. So they isolated Dominic for 42 days in a old unused part of a Leprosy center. Dominic, a staff with Worldwide fund and a regular blood donor went through tremendous psychological stress of being denied his human rights and basic amenities (food was pushed into his room without the provider entering his room; water was provided from the toilet tap). Dominic's family, friends and villagers stood by him and forced the Government to release him. Lawyers' collective stepped in for legal issues of stigma and discrimination a first for legal issues.

Dominic became the first spokes person and advocate for the rights of PLHA and more importantly to talk about HIV and how youth can protect themselves. He came to Chennai and spoke to youth in universities.

In Tamil Nadu, Mr Sekar from SWAM was one of the first positive MSM to voice the experiences and concerns of MSM who were testing positive. In 1993, his impending marriage led him to test for HIV. Confident in the notion that HIV was an infection that was only transmitted from female sex workers, Sekar underwent the testing in Apollo Hospital which was the only private sector offering the test at the time. Testing positive opened the Pandora's box for Sekar as he had to deal with double discrimination for his sexual orientation and his positive status. In his family his siblings and relatives felt ashamed more about the source of his infection than HIV itself. The misconceptions regarding transmission of HIV mosquito bites, living in the same house, touching led to complete ostracization by the society he lived in forcing him to take up residence in a remote area. Alienated and lonely, but never disheartened, Sekar came in contact with Senthil, another MSM social worker and CAN, an NGO. This turned life around for him. He advocated the cause of MSM and PLHA all across the state, country and represented India in international forums. By 1997, Sekar registered Social Welfare Association for Men [SWAM], a CBO, which brought together like-minded people and they worked for prevention of HIV among MSM. SWAM set up a drop-in center and short stay home to facilitate interaction and confidence building among MSM PLHA. Currently his concern for the female partners of MSM and low esteem of MSM in general, has led him to collaborate and plan activities to address this issue. Sekar continues his efforts for positive prevention among PLHA and is hopeful of mitigating the impact of the epidemic.

INDIAN NETWORK FOR PEOPLE LIVING WITH HIV/AIDS (INP+)

Ever since the first detection of the virus HIV, in India in the year 1986 many individuals have tested positive. In the year 1994 & 95 some of the PLHAs met together informally to discuss these issues in Chennai, Pune and Delhi. They realized the need to network so that their many voices would be heard as one. On 20th February 1997, twelve people living with HIV/AIDS (PLHAs) from different states in the

ORGANIZATIONAL DEVELOPMENT IN RESPONSE TO HIV/AIDS EPIDEMIC

country, met to discuss the issues faced by them. This led to the foundation of Indian Network for People Living with HIV / AIDS or INP+. INP+ was registered as a Society, in May 1997, under the Tamil Nadu Societies Registration Act under the president ship of DrTokugha Yepthome.

The organization aims to improve the quality of life of people living with HIV in India and exists to provide sense of belonging and togetherness to people living with HIV. INP+ has partnerships with state level networks in Maharashtra, Karnataka, Goa, Tamil Nadu and Manipur and Positive Women's Network of South India.

INP+ uses a holistic approach to effectively reach out to PLHA and to strengthen the existing PLHA network. All networks go through a periodical capacity needs assessment, visioning exercise in order to strengthen, and stay focused on their organizational goals. As part of the capacity building, PLHA from different walks of life require training to form and facilitate support groups, develop expertise in HIV/AIDS issues and to be effective advocates of change. Technical training in governance, leadership, MIS, and other required skill is arranged for the networks using internal and sometimes external resources.

TAMIL NADU NETWORK OF POSITIVE PEOPLE (TNP+)

Registered as a Trust in the year 1995, Founder and Director Mr. Rama Pandian

The Tamil Nadu Network of Positive People (TNP+) provides counseling services to the infected and the affected, information and educational materials on all aspects of HIV/AIDS, treatment of opportunistic infection and home care services for PLWHA through community care centers and drop-in centers and various awareness and advocacy programs in the state The network organizes and conducts meetings, training courses workshops, conferences and capacity building programs for PLWHA and relevant people on positive living, yoga, self care, prevention, counseling leadership training of trainers, positive speakers, confidence building, treatment literacy and advocacy. The agency is currently implementive programs in Chennai, Kanchipuram, Cuddalore, Thiruvallur, Namakka, Villupuram, Dharmapuri, Coimbatore, Trichy, Dindugal, Madurai, Tirunelveli districts of the state.

The HIV Positive people welfare society (HPPWS) is the state level network affiliated to INP+ in Tamil Nadu through an MoU. Though an independent organization, together with other state level networks they form INP+. Their major function is to network, build and maintain linkages with the local State AIDS Control Society (TANSACS), other agencies working in HIV/AIDS and with the community at large.

The other positive peoples networks functioning in the state include the South Indian Positive Network, The Cuddalore district HIV+ Society (CDS+), The Dharmapuri District Network of Positive people (DDNPS+), the Positive's association network (PAN), the HIV Ullor Nala Sangam (HUNS). The People Living with and Affected by HIV/AIDS Trust (PLAAT), Trichy District Network Of Positive People Society (TDNPS+), Thiruvannamalai District Network Of Positive People (TDNP+), Community Of Pepole Living With Hiv/Aids In Tamil Nadu and Vellore District Network Of Positive People (VNP+)

Supported by TANSACS, CAPACS the agency is currently implementing programs in Chennai, Kanchipuram, Cuddalore, Thiruvallur, Namakka, Villupuram, Dharmapuri, Coimbatore, Trichy, Dindugal, Madurai, Tirunelveli.

POSITIVE WOMEN NETWORK (PWN+)

PWN+ of south India is a self help organization of women living with HIV. PWN has its headquarters in Chennai, Tamil Nadu. PWN+ was registered as an organization in 1998. They are working in Namakkal, Erode, Perambalur, Trichy, Madurai, Theni, Tirunelveli, Virudhunagar. The goal of PWN+ is to provide an enabling environment of women living with HIV, to educate WLHA and their families in order to increase their awareness of issues affecting them and to work towards the empowerment of WLHA.

PWN+ has also been an outcome of the efforts of TANSACS. As a symbolic gesture, in 1997, TANSACS employed two HIV positive women, both widows of transport workers who died of AIDS. Since 1998, TANSACS has laid down a condition of employing at least one HIV infected person for NGOs to qualify for funding (TANSACS, 1998).

HIV POSITIVE PEOPLE WELFARE SOCIETY (HPPWS)

State level Networks are the face and voice of people living with HIV in states across India. HPPWS is the state level network affiliated to INP+ in Tamil Nadu through an MoU. Though an independent organization, together with other state level networks they form INP+. Their major function is to network, build and maintain linkages with the local SACS, other agencies working in HIV/AIDS and with the community at large.

SOUTH INDIAN POSITIVE NETWORK(SIP+)

A network formed to reach marginalized populations, the SIP provides counseling, and emotional support to PLHA, drop-in centers where members can interact and share concerns as well as leisure activities. They also provide short stay facility for those accessing care from Tambaram Center. Prevention, care and support programs are conducted by the members at Chennai and Kanchipuram.

Besides the above mentioned networks there are various district level positive networks supported by TANSACS

- 1. POSITIVE'S ASSOCIATION NETWORK (PAN) Erode
- 2. HIV ULLOR NALA SANGAM (HUNS) Namakkal
- 3. PEOPLE LIVING WITH AND AFFECTED BY HIV/AIDSTRUST (PLAAT), Madurai
- 4. CUDDALORE DISTRICT HIV+ SOCIETY (CDS+) Vadalur
- 5. DHARMAPURI DISTRICT NETWORK OF POSITIVE PEOPLE Dharmapuri
- 6. TRICHY DISTRICT NETWORK OF POSITIVE PEOPLE SOCIETY (TDNPS+), Tiruchirapalli
- 7. THIRUVANNAMALAI DISTRICT NETWORK OF POSITIVE PEOPLE (TDNP+)
- 8. COMMUNITY OF PEPOLE LIVING WITH HIV/AIDS INTAMIL NADU
- 9. VELLORE DISTRICT NETWORK OF POSITIVE PEOPLE (VNP+)

Sum Up:

Collective efforts of different sectors—government, NGOs, private sector and people infected and affected by HIV are not only responsible for stabilizing the epidemic in Tamil Nadu but also have demonstrated a partnership model to other states as a success story. The responses at each level within organisations and policies have been sensitive to the need of the populations in the state. The shift from mass education to focused interventions among high-risk population effected changes in the organizational level. Adoption of new strategies, keeping pace with the changing national and international perspectives, necessitated involvement of agencies with different skills and expertise to come together. The political will in the state and a flexible approach to learn and evolve new models, even when it meant large-scale restructuring has provided an environment for successful interventions. The last decade of combating HIV in the state, has also brought out lessons learnt to understand and respond to the multiple needs and challenges that the epidemic poses from time to time.

Now at the threshold of NACP III Tamil Nadu is up-scaling its response through organizational integration within all governmental departments by "Mainstreaming" HIV/AIDS and also expanding its partnership with private with the motto "HIV is Every Body's Business"

A team under the leadership of Dr Praneeta Varma, APAC-VHS, conducted interviews for this section

- 1. Dr. Krishnamurthy, PD, APAC-VHS Ms Sunanda & Praneeta
- 2. Dr. Radhakrishnan, Blood Safety, MGR Medical University-Praneeta & Gladston
- 3. Dr. Kantharaj, Consultant-Gladston
- 4. Mr. Ramasundaram Ms. Sunanda
- 5. Ms. Umaravikumar for CAN Mr Mohan
- 6. Mr Ganesh for ARFI Mr Mohan
- 7. Ms Indhu for SIAAP Praneeta
- 8. Networks Gladston and Praneeta
- 9. TNVHA Mr Mohan
- 10. APAC (PD, Mr Jim, Mr Ashok Babu, Chandrasekhar, Ms Sandhya)
- 11. Data searching Praneeta and Ms Gita
- 12. TANSACS data Praneeta, Jagadeesan, Sunanda
- 13. Mr Sekar SWAM Praneeta
- 14. CHES Dr Manorama



EAS **Bimal Charles &** P. Krishnamurthy **CONTEXT OF** PREVENTION IN TAMIL NADU

remained a myth in the country in the early 80s after the problem was first recognized in the west. The academic community and the virologists discussed this as a disease among the so-called "bad people" the Gay men, prostitutes and those with immoral behavior of the West. Tamil Nadu was thought to be immune to the spread of this virus and the State was considered to be having "well behaved populations", conservative men and women who behaved within the framework of societal norms of having sexual relationship only within the marriage.

It was a shock in 1986 when it was reported that the virus has in fact reached India. ¹The initial reaction by the government was to impound all those infected without realizing the effects it could have on the prevention program in the future. There was even suggestion that screening of all foreigners be initiated to prevent further spread in the country. Tamil Nadu had to quickly learn from the international experience and initiate interventional

programs to control the spread of disease in the state. The African data showed that HIV is transmitted mainly through un-protective sexual intercourse with an HIV infected person. Thailand showed that 100% condom use in high risk sexual activity is effective in controlling the epidemic. ^{2,3} As these information became available the real source of infection got identified and attention got focused on high risk groups like sex workers and vulnerable groups like men who were on the move.

The core activities on prevention undertaken by TANSACS can be summarized as under.

- Awareness programs and IEC campaigns
- Targeted interventions among high risk categories
- Blood safety measures and standardization of blood banks
- STD control measures and improvement of clinical services
- Capacity building of TANSACS and Partners

Information, Education and Communication activities (IEC)

Awareness creation is the key to effective HIV prevention programs. Multi pronged communication strategies to support preventive strategies were initiated in the general population, and in vulnerable subgroups mainly the youth in and out of campus and women groups, high-risk groups and health care providers. The



IEC for women groups

strategy was wide based and used effective combination of electronic, print, and interpersonal communication. Some of the important strategies adopted by Tamilnadu is listed below:

Targeted Interventions (TI)

TANSACS has implemented TI programs in a wider level with effective strategies by collaborative efforts of NGOs working for HIV/AIDS in Tamil Nadu. NGOs were placed in all districts of Tamil Nadu for bringing out behavioural change among the community to control HIV/AIDS epidemic. Selection of NGO/CBO is in accordance with NACO guidelines.

TANSACS has 112 ongoing NGOs projects for specific targeted intervention programs, which include 3 DFID Projects and 2 Community Care Centers.

Table 9 : GROUPWISE NGOs POSITIONED FOR THE YEAR 2001 - 2002 & 2002 - 2003

QI.	Type of Intervention	No. of NGOs					
SI. No.		Positioned in 2001 - 2002	Positioned in 2002 - 2003	Ongoing			
1.	Truckers	4	15	19			
2.	CSWs	12	15	27			
3.	Industrial Workers	11	11	22			
4.	Migrant Workers	12	6	18			
5.	PLWHAs Network	3	6	9			
6.	Research Study	2	1	3			
7.	CARE	2	1	3			
8.	Community Care Centre	2	-	2			
9.	MSM -			2			
10.	Students	-	-	-			
11.	Prisoners	-	3	3			
12.	Tribals	-	2	2			
13.	NGO Training Centres	-	2	2			
Total		48	64	112			

Figure: 20 Type of Interventions, care & support and TI training for Partners

Types of Interventions

MSM
Trucker Drivers
Industrial Workers
General Public
Migrant Workers
Tribals
Child Laborers
Prisoners
CSWs

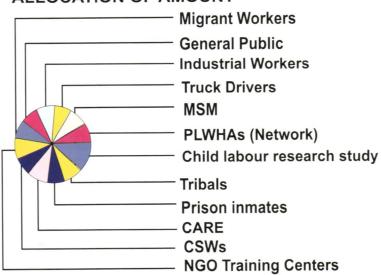
Care and Support

PLWHA Networks Care Centers

TI Training for Partners

NGO Training Centers

ALLOCATION OF AMOUNT



SHG Intervention Program

Tamil Nadu developed a behavioral intervention program that proposes to equip women members of Self-Help Groups with adequate knowledge about HIV/AIDS/STI and necessary capacity and skills required to make informed decisions on their sexual and reproductive health. Through the program 3,100,000 women in almost 1,55,000



Groups were covered in the State. This activity works in close coordination with Tamil Nadu Corporation for Development of Women,

Red Ribbon Clubs (RRC) in Higher Educational Institutions

Youth in educational institutions were targeted through Red Ribbon Clubs which were established in higher educational institutions in Tamilnadu RRC program initiated intervention towards HIV/ AIDS prevention, mitigation, stigma reduction. It also promoted students and teachers to be agents of change by developing skills on leadership.

Prevention Programs among the Youth

Youth, in the age group of 15 to 24 years are at higher risk for contracting HIV. Thus, from 1993 to 1996, with the support of the Ford Foundation, Dr. Suniti Solomon began presenting hour-long programmes



Students' Programmes for Public

about HIV/AIDS at schools and colleges within Tamil Nadu. The educational institutions were at first hesitant participants, maintaining that HIV/AIDS was a health issue faced only by sex workers and not by the country's young people. Students, however, exhibited interest in the programmes, raising many questions during doubt clarification sessions following the presentation.

It was noted that the students' concerns were not limited to HIV/AIDS, but also pertained to

sex and sexuality, indicating a need to broaden the scope of the presentations to address these issues. With the aid of a volunteer from the Overseas Service Bureau (OSB) of Australia, the staff at YRG CARE developed a module addressing both HIV/AIDS and sexuality. "Learning to Play Safe" was presented by YRG CARE trainers in one-day sessions to students in 11th and 12th grades and in two-day sessions to college students. For the latter group, emphasis was also placed upon values and issues surrounding living with HIV.

The module was well received by its target audience, and YRG CARE sought to reach out to all schools across the state. With only four YRG CARE trainers available, the decision was made to enlist teachers in the educational effort. With the support of the Ford Foundation, from 1996 to 1999, trainers led three-day workshops designed to enable teachers to serve as HIV/AIDS educators. However, focus group discussions held six months post-training indicated that a lack of support from colleagues and parents and reluctance to discuss matters concerning sex and sexuality were hindering teachers' efforts in schools. Acting upon the suggestion that local NGOs should therefore also be involved in the educational programs, YRG CARE began to train staff of interested NGOs alongside teachers. Enhancing the efficacy of communication with students was also addressed by training students themselves through the Peer Educators Project, which was carried out from 1994 to 1999.

From 1999 to 2002, efforts were taken to scale-up the activities of 11 NGOs who expressed an interest in further developing their adolescent sexual awareness programs. Again with the backing of the Ford Foundation, YRG CARE spearheaded the scale-up, holding workshops for staff members of these NGOs on topics ranging from resource mobility to patient counseling. YRG CARE staff also monitored the activities of these organizations following the training period.

Four of these NGOs, along with YRG CARE, were selected as core organizations responsible for aiding UNICEF and the TANSACS in the implementation of the School AIDS Education Programme (SAEP) during the 2003-2004 academic year.YRG CARE continues to be involved with the SAEP and is responsible today for the training of officials, teachers and peer educators in six districts of Tamil Nadu. In the 2004-2005 academic year, the SAEP reached nearly 8,188 schools in the state. The

"Learning to Play Safe" module, first developed by YRG CARE nearly a decade ago, continues to be used in the SAEP to educate youth today.

School AIDS **Education** Program (SAEP)

TANSACS initiated NACO supported SAEP program in the state very effectively since 1997. The program targets children in



Students - UNICEF Programme

the pre reproductive and reproductive age groups in collaboration with Directorate of Teachers Education Research and Training (DTERT). It is implemented by the department of school education and supported by UNICEF. The program has achieved 100% coverage in all Government schools and is also reaching out to the private schools in the State. Every year about 16.5 lakh students, from Secondary and Higher Secondary Schools, in the age group of 14 to 18 years in IX and XI Standard studying in Government, Government aided and matriculation schools in the State have been targeted through the program

Program for Out of school youth

As the School AIDS program was successfully initiated, it became apparent that youth who are out of the formal education system are more vulnerable to risky behavior, TANSACS has positioned the Out of School Youth Program as a key intervention for preventing new infections, reducing vulnerability to the infection and influencing positive behavior development. The program has been initiated in 6 districts with the State Resource Center as the main nodal agency. The districts are Trichy, Salem, Perambalur, Dharmapuri, Tuticorin and Erode.



Street-plays demonstration on world AIDS Day - 2004

In each village, the Continuing Education Centers will form the focal point of this program which will have a module designed for a period of 12 hours. TANSACS and UNICEF also support State Resource Center and Nehru Yuva Kendra respectively to reach the out-of-school youth in Tamil Nadu.

Blood Safety and Voluntary Blood donation activities

From the time of the 1st HIV case, there has been considerable effort to upgrade the blood bank services in the state. The program has set up 84 blood banks in the public sector. Of these 49 are designated as Regional Blood Transfusion Centers approved to Conduct Blood Donation Camps by The Tamilnadu State Blood Transfusion Council. In addition there are 33 Blood Storage Centres (BSC) established. Through these banks all the blood are screened for 5 mandatory screening tests to reduce blood borne infections including HIV. One of the main problems in the quality of blood is the proportion of voluntary blood donor who contribute to blood donation. This proportion has increased to 82% in Government Blood Banks and 64% in Private institutions and is very well above the national average of 48%.

Condom Promotion activities

Conodm is the mainstay of HIV/AIDS preventive strategy. The state has given high priority to condom promotion among people, both high risk and other vulnerable populations. TANSACS have adopted different strategies targeting different risk populations in the state. These include:

- Distribution of free condoms (Nirodh) to the people through health care institutions, STD clinics, out reach camps, and also through NGOs.
- Promotion of subsidized or low priced condoms (Deluxe Nirodh) among the people in TI areas and Non intervention areas with the support of Non Governmental Organizations.
- 3. Promotion of condom usage and popularizing the concept of safe sex and condom usage through awareness and Behavior Change Communication



Mobile Health Education & Condom Promotion

Government of Tamil Nadu initiated social marketing of Condom through ration shops (PDS)

Promotion of free condoms through Fair Price Shops is one of the most successful activities carried out by TANSACS in condom promotion. Fair Price Shops exist in most of the villages in rural areas and access to condom to all those who need it in confidence has been greatly facilitated through this strategy. The program is run in collaboration with department of cooperative societies.

Other initiatives by the state include promotion of female condoms and increasing proportion of social marketing of condoms in the state. However these have not gained wide acceptance in the state and socially marketed were confined largely to chemist outlets.

STI/RTI Care and Out-reach Services

During 1993 there were 57 STD clinics were functioning at the district level in the state. It has increased to 100 by 2004. All STD clinics have necessary equipment and laboratory support, including counseling facilities. The drugs are supplied for the effective treatment of the patients attending these STD Clinics. Counseling is provided to the attendees in outreach camps and also at STD clinics. Condoms are supplied to the clinic attendees free of cost. Partners of the patients are notified for improving effectiveness of the treatment and follow up services and to reduce the risk of transmission. However utilization of STD services in the state has remained very low probably largely due to lack of access of these facilities to vulnerable populations and lack of privacy for STD care in the clinics often attached to district hospitals of the state.

Family Health Awareness Campaign (FHAC)

FHAC has not only created awareness about RTIs and STDs among masses but also provided some opportunities for screening and treating those infections. These campaign works in Inter-sector coordination with all available field level machinery under the Health and Family Welfare Department. The campaign had an interpersonal communication drive consisting of house-to-house visits and a social mobilization initiative with village camps where information is given to all stakeholders in the community. This is supported by a mass media campaign to inform people about the campaign. The campaign also had trainings for medical personnel on the syndromic management of STIs.

Interventions targeting Injecting Drug Users (IDUs)

IDU related outreach interventions were launched by SAHAI Trust, a church based non-Governmental agency in 1994. Outreach services for injecting drug users at Chennai have been evaluated and found to be effective in reducing injection related HIV risk behaviours. Currently targeted interventions for IDUs in South and North Chennai are being supported by CAPACS and APAC proposes to maintain interventions in Central Chennai. TANSACS is supporting IDU interventions in Madurai since last year. The targeted interventions emphasize on outreach based services, behaviour change communication, provision of injection equipment, condoms and STD management. At present the IDU interventions are lacking in adequate coverage and comprehensiveness. For example, the drug substitution treatment is available for only a very small proportion of IDUs.

Response of Faith Based Organization:

Initiation of faith based organization in Tamilnadu began during early 1990s. However there has been limited success.

Integrated Counseling and Testing Centers.

TANSACS has now established 275 Integrated Counseling and Testing Centers both in Government and Private sectors through PPTCT and VCTC Services. During the year 2001 - 2002, 26,324 individuals were screened and 1902 persons were found to HIV positive. VCTCs have been established in all Districts HIV VCT have been shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV sero status in a confidential environment with counseling and referral for ongoing emotional support and medical care. People who have been tested sero positive can benefit from earlier appropriate medical care and interventions to treat and /or prevent HIV - associated illnesses. Pregnant women who are aware of their sero-positive status can prevent Transmission to their infants. Knowledge of HIV sero-status can also help people to make decisions to protect themselves and their sexual partners from infection.

PPTCT (Currently an integral part of ICTC) Program

The PPTCT program has tested 6.5 lakh mothers HIV on voluntary basis with consent. Nearly about 1600 mothers have delivered at PPTCT Centers safely with NVP prophylaxis and nearly 120 children at 18 months were checked for HIV status and only about 14 of them were found to be positive for HIV.

AIDS Prevention and Control Project (APAC)

APAC project started functioning in 1995 in Tamil Nadu with support from USAID, with the goal of reducing the sexual transmission of HIV in the State. APAC was designed to complement the prevention efforts of the State government in Tamil Nadu and enhance the non-governmental response. The main components of interventions at that time were 1) NGO interventions, 2) NGO support and development 3) Capacity building of service providers and 4) Research.

The main objectives were clearly preventing the epidemic in Tamilnadu and consisted of the following

- To strengthen capacities of NGOs in Tamil Nadu and Pondicherry to implement TI and care and support initiatives.
- To increase knowledge and demand for HIV/STD prevention products and services.
- To increase the access and utilization of high quality condoms among target audience.
- To improve access to high quality STD treatment and prevention services.
 To facilitate collection of data to support HIV/AIDS programming.

Targeted intervention (TI)

The NGO program decided that it would intervene among the core transmission group of sub population only targeted interventions, which would reduce the transmission to the general population.

The concept of targeted intervention reaches people who have the likelihood of being infected with HIV and of infecting their sexual partners and at aims reducing the risk using a mix of interventions. The twin approach to promote safer behavior options to the targeted group and promoting quality services for the group ensures reduction in the transmission of HIV from the infected to the uninfected.

To develop and implement this concept to a State level program required several strategic approaches which include behavior change communication mass media campaigns, enhanced quality services for STD care and counseling and products for prevention (like condoms).

Several strategy workshops were organized to prepare plans for implementing targeted intervention. The first strategic workshop focused on prioritizing high-risk groups, intervention settings are locations. Secondary data from several sources facilitated prioritizing high-risk groups in the State, which could be addressed to reach the overall goal.

A behavioral survey was designed and conducted along with mapping exercise in the State in 1996. The exercise highlighted the estimates of available sex workers in the State, their conglomerations, networks and potential hot spots for intervention. At the same time data from NGO partners was used

to identify major truck halting points in the State and the potential sites for intervention, among truckers and helpers. A desk research identified the potential populations of young people available in urban slums for intervention.

Awareness level among adult population had considerably increased since the initial assessment by APAC. Therefore it was necessary to have additional behavior information on sub population groups. TANSACS efforts had raised the awareness among general population and it was necessary to sustain the momentum.

Table 10:

Trends	Trends in AIDS awareness in the central adult population in Tamil Nadu						
Year	% of sample who had heard of AIDS	Source	Sample				
1992	23.4	NFHS	Ever married women				
1995	46.5	NFHS	Ever married women				
1996	91.7	TANSACS	General adult population				
1997	93.5	TANSACS	General adult population				
1998	97.0	TANSACS	General adult population				
1999	87.3	NFHS	Ever married women				

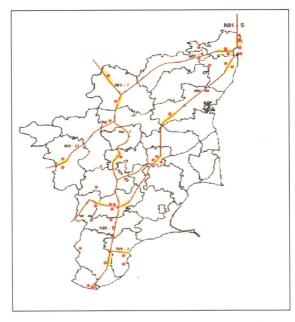
The first round of Behavior surveillance survey established the high level of awareness among various groups of populations groups in Tamil Nadu. The subsequent studies indicated the consistent highly levels of awareness among these groups.

The high risk groups, prioritized for intervention were women in prostitution, long distance truckers and their helpers, young people living in urban backward settlements, male and female factory workers and men having sex with men. In its first phase of intervention (1996-2000) the focus was on reaching a substantial number of women in sex work, trucking industry and young people. A number of thematic strategy meetings to design programs were organized for each of these groups (Source: Unpublished paper from APAC).

Based on rapid assessment, 18 clusters were prioritized for intervention within the State based on some simple criteria to define these geographical areas. The NGO partners involved in PATH interventions undertook the 24 hours traffic census for a week along the highway and mapped major halt points to start intervention activities. NGOs implementing WIP interventions mapped their area to select intervention sites based on pick up points and the encounter points. NGO staff identified brothels and lodges in the area and identified gatekeepers of the trade (pimps, brokers and brothel keepers). Private health care providers and non-traditional outlets selling condoms in the area were also identified and mapped by NGOs. The criteria used to prioritize interaction locations were density of population, density of women in prostitution, density of floating population, presence of factors promoting people movement (like markets, tourism, religious places and industries) and presence of national/State highway closer to the area.

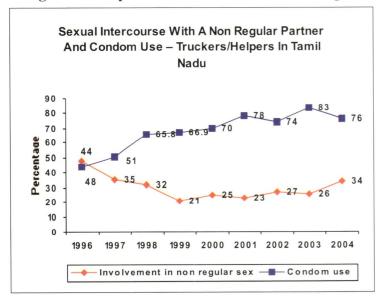
Strengthening NGO network for prevention

An assessment of NGO capacities in 1995 revealed that NGOs in general had some idea of prevention but lacked the technical and administrative/financial capabilities and systems to implement large scale prevention efforts. Specific plans were made for building NGO capacity. The approaches used to develop NGO capacities included Well-designed training programs for NGO managers, Specific technical orientations for field workers and counselors. Training on communication and trainers program for developing peer education program, Training for counselors on principles of counseling, On site technical support and assistance by experts, Experience sharing meetings and reviews with technical input on special topics, Guided exposure visits for NGO staff to similar intervention projects



else were the country and Sponsorship for national and international conferences and training programs (Source: APAC annual report 2003).

Figure 21: Implementation of technical strategies



APAC organized strategy meetings for each of the technical strategies. The communication strategy meeting suggested plans for implementing the BCC approach of APAC. A communication needs assessment survey was undertaken and these core messages, channels and indicators for measuring progress were finalized. The first behavior surveillance survey 1996 indicated a high level of awareness among CSWs, Truckers and male factory workers. However, the same groups reported low use of condoms in their last sexual intercourse. Male and female

students reported high level of awareness and their involvement in sexual intercourse with the non-regular partners was low (3%). Hence, APAC decided intervention among sex workers and truckers in a significant way.

The program used the services of communication agencies to design and produce materials for prevention. Several small media materials were prepared, pre-tested and produced in sufficient quantities to help communication by NGO staff. It was decided to produce these materials to standardize messages and materials. An assessment revealed that the materials available in the

State were not standardized as it was designed and provided by NGOs. The materials provided inaccurate information and were open to variable interpretation by the user. Moreover the messages created panic in the community and hopelessness for population PLHAs. The program followed the policy of standardizing messages across the State. However, NGOs and peer educators were encouraged to design concepts and materials and share them with other partners at experience sharing and review meetings. Thus, the field level creativity was encouraged in material design.

One of the important strategy was for enhancing the access and quality of STD care in the State for groups intervened by the NGOs. It was envisaged that behavior change communication by NGOs and by the media would improve treatment-seeking behavior for STIs among the targeted population groups, which would lead to demand for improved STI services, and these services should meet the demand for STI care services.

A Plan was developed to improve their quality and access, using a capacity building approach for private providers and networking with the existing providers. Five training partners were identified in the State and their capacity was enhanced as training resource for training quality private providers. Special training of providers in STD case management through CETCs was initiated in July 1997.

A large number of Allopathic private practitioners (APP), Registered indigenous medical practitioners (RIMP), Pharmacists, Auxiliary nurses and midwives (ANM) and Community health workers (CHW) were trained by the program during the last 10 years. CETC-NGO interactions were organized and this process helped in identification of Allopathic doctors as trainers for CETC training program.

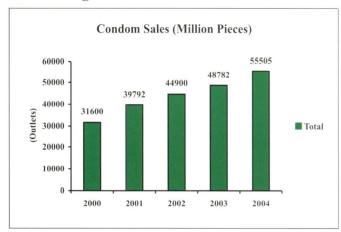
Building referral linkages for STD care with local health care providers

Special effort was taken by the initiative to build referral linkages with providers in their area to ensure that target populations get high-quality STD care. A strong partnership between NGOs and local governments in the implementation STD/HIV/AIDS programs, and NGOs have facilitated the linkages of services their target populations. CSWs who can pay use the services of private providers are referred to these providers trained by the program. Others who can't pay are linked to public sector providers, trained by TANSACS in STD case



management. NGOs have appointed and trained counselors who are located in government hospitals, which lack counseling services.

Figure 22: Condom Promotion



Significant increases in commercial sales of condoms in the State has been achieved as a result of interventions. These sales figures are beginning to plateau, however. The reasons include inadequate commercial sector interest in expanding total condom sales, especially in peri-urban and rural areas. There is need for more training for non-traditional vendors and to sustain the increase.

Private Sector Collaboration

Figure 23 : Condom use with clients / live in partners commercial sex workers

2000

Regular Clients

2001 2002

Sales of fully priced (commercial) condoms in Tamil Nadu have increased significantly since 1995. The biggest jump in sales, however, occurred during 1996-97, when both JKAL and Hindustan Latex Ltd. (HLL), participated in a pilot condom marketing effort. JKAL acknowledges, however, that its primary interest in the activity is to increase its market share in southern India-an objective, which may or may not contribute to an increase in the total demand for condoms (personal communication Mr.Aravind Kumar, Former condom specialist APAC).

Focus group discussions with the truckers show that they prefer casual sex to paid sex. The paid sex workers have many partners. Condom usages in casual sex were shown significant increase over the years. However, perception of risk who have involved in unsafe sex increased among truckers over the years.

Condom Use with Clients/Live Partners - CSWs

Availability of remedies and medicines

Availability of fake medicines and anti retroviral affect the perception of risk and impact prevention programs negatively. The program documented increasing encounters by truckers when anti retroviral drugs were made available. There were lower perceptions of risk by men when the media carrying unproven treatment options by quacks in Tamil Nadu. There was increase on usage of condom and increase in the percentage of men taking multiple partners in female factory workers and male factory workers.

Percentage

60

40

20

0

1997

1996

- All Clients

Community participation in prevention

The level of community participation has varied in the State over the years from participating peer

educators to contribution by raising resources. The community of sex workers has mainly contributed as educators and some have even organized their own communities to found registered societies. Some of these registered societies have started savings and welfare for sex workers and their families. Peer educators from the trucking industry have even mobilized resources to prepare and distribute education materials for HIV/AIDS. However, the efforts of peer educators on groups rely very much and motivation and support offered by NGOs.



Community Participation with NGOs

Strengthening Services for prevention

Prevention intervention need quality services and follow up from health care providers in the State had specialize service STD from the government and the private sector. Services from unqualified/informal health care providers and counseling from NGO supported outlets. The national program had proposed strengthen of STD services in the State through the public health facilities. The State had 57 STD clinics attached to government hospitals, which were strengthened with better infrastructure and medicines. The physicians managing these clinics received training in syndromic management of STDs. The utilization of these clinics continued to be low and has there been no outreach and follow up possible from these centers. The private sector physicians who were treating more than three STD patients per week were identified and trained by trainers across the State. More than 4000 private doctors were trained 2005.

Counseling as a service for prevention was developed at the NGO level. NGOs were funded to recruit counselors who offered services to communities at large. The focus was on prevention, treatment for STIs and appropriate use of condom as a preventive device. The training for counselors was undertaken by expert counselors in the State often in the local language. The counselors also stressed on the treatment of sexual partners for STD conditions.

Transparency in program

HIV outreach work is built on trust and confidence. The State implementing agency and NGOs have to depend on the commitment and the dedication of its outreach staff in their prevention of work. Openness and transparency are key elements to promote improved performance by the staff. This requires participation of individual staff and NGO leaders at various levels and the ability of State level organization to built confidence and trust. Participatory site visits for technical and financial assistance and observation of the field level activity and the sharing of information with NGOs and its

staff was a critical element in program management. This was well appreciated by NGO partners and its staff. Even in instances there was under performance or improper reporting of transactions the observations were made transparent to partners. This resulted in open exchange of information including some of the field level problems and institutional barriers. It was always possible to find solutions to some of the most difficult issues at the institutional level.

Networking

Networking is accomplished at the following three levels, and contributes substantially to capacity building among the participating NGOs.

Networking between NGOs is one of the principal goal of the ESRMs, organized every 6 months for NGOs working in a particular thematic area (e.g. WIP, PATH). ESRMs are typically attended by NGO project staff, consultants, and technical and financial management staff. Performance of each project is reviewed and problems and ideas for their solution are exchanged and discussed. Minutes are maintained for continuing reference. NGO representatives praise these meetings as support to their work and a boost to their morale.

Networking among NGOs in each of the eight geographic clusters into which they are divided is achieved by bringing together individuals and NGOs involved across all thematic interventions in that cluster. These meetings are also convened on a 6-month basis and serve as a valuable opportunity for participants to be exposed to and learn from the full range of prevention activities.

Impact of targeted interventions in Tamil Nadu

Behavior surveillance in Tamil Nadu has captured the impact of targeted intervention in the State. The impact is a combined result of several agencies working in the State in tandem to reduce the risk of HIV spread from the infected to the non-infected. The prime players in this effort have been APAC, TANSACS and CAPAC. There are other smaller players who have also contributed to the changes in the behavior of high-risk group populations. CCOORR funded 8 NGOs with assistance from CORAID and European donor and this group has also worked in 8 temple towns. YRG care foundation worked with schools to raise awareness among school children. Similar efforts by DESH in schools have been recognized. YRG work with industry in Tamil Nadu reaching 24000 work force.

The knowledge indicator remained high in all groups since 1996. Condom usage during sexual intercourse with non-regular partners increased among truckers and CSWs and raised 87%. This behavior has remained higher this level since 1999. CSWs have started using condoms with their regular clients. However, this behavior remains low with their living partners. A high proportion of sex workers (83.8) and truckers (98.5) seek treatment from qualified allopathic practitioners. Perception of risk has increased among CSWs and truckers. The average number of clients per day for sex workers has not changed whereas truckers have reduced their involvement in paid and casual sex. Male factory workers of late have increased their involvement in non-regular sex, while the perception of risk is only 61%. Male youth in slum groups continued to involving in non-regular sex while their condom use has increased and the perception of risk has shown as slightly increased.

Table 11:

Trends in AIDS awareness in selected population groups in Tamil Nadu									
Population group	Aware of two methods of preventing HIV/AIDS								
1 opulation group	1996	1997	1998	1999	2000	2001	2002	2003	2004
CSWs	86	98	96.6	98	98.2	98.5	98.25	98	95.2
Transport workers	95	97	96.1	96.5	96.1	99.6	97.5	97.8	94.8
Male factory workers	93	98	97.9	98.8	99.1	99.3	98.6	98.2	96.1
Female factory workers	81	94	89.1	90.7	97.2	98.6	97.3	93.62	93.3
Male youth in slums					98.7	99.3	95.19	96.1	99.7
Male students	88	93					97.3	92.4	
Female students	70	84					93.2	75.2	
MSM						97.6	99	82	98.7

Source: APAC - BSS

The data in the tables are show that, by the late 1990s, awareness about AIDS was high in the general adult population and selected high-risk/ core transmitter groups like CSWs and transport workers in Tamil Nadu. Further, awareness levels in Tamil Nadu were also higher than in any other part of India. During the years 1995-1998, the expenditure on awareness campaigns in Tamil Nadu was more than total expenditure for such campaigns in the rest of India. This universal awareness created an environment for targeted interventions to be very successful in Tamil Nadu, which brought about the behavior change that is a pre-requisite for slowing down of the epidemic (Source: CMH working paper). However there are other states which had similar high level of awareness and targeted interventions have not created similar behaviour change, which shows the quality of interventions and the capacity building processes that accompany are critical for interventions to be effective.

The state can capitalize on the prevailing environment of collaboration to ensure that a uniform training procedure for STD case management is adopted and comprehensive strategy is incorporated into the public sector system.

A recent evaluation shows that about 53% of AMPs were using the syndromic approach to treat STDs. About 30% of RIMPs and 66 percent of pharmacists (who are expected to refer cases) were prescribing drugs for STDs. Moreover, pharmacists did not appear to be aware of the correct dosage and duration for the drugs they prescribed. The prescription of antimicrobial drugs without the correct application of the syndromic approach could fuel already existing drug resistance problems.

The quality of follow up of trained providers is an issue. One CETC has been able to follow up about 75% of providers they have trained, while the others have followed up about half of all trainees. The CETCs use social workers for follow up visits, a problem with AMPs who do not perceive them as peers. In addition, the structured questionnaires used for follow up do not enable CETCs to identify gaps in learning and restructure training content.

Private sector partners

Private medical institutions and individuals offered the services to the State and willingly participated in many of the initiatives for prevention. National Institute of Sales (NIS) has trained more than 5000 retailers in small trades to participate in the promotion and sale of condoms in the State. Several communication agencies have helped to design and produce mass media campaigns and small media materials for BCC. The communication agencies used by APAC, TANSACS and CAPACS brought in their expertise in message design and media packaging to the table. The private sector

electronic media facilitated messaging in the open space to initiate and this has maintained high levels of awareness among the masses.

Am I at risk

The concept of attributing personal risk of contacting HIV was the challenge. The tendency has always been the others are addressed. The behavior surveillance indicated many were aware of HIV/AIDS but were not able to translate it to themselves. The program has documented that sex workers were using condoms while having sex with their non-regular partners and use of condoms with regular partners was low. Focus groups discussions revealed that the perception of risk was low with intercourse with regular partners or known clients. The known customers and their husbands (living partners) were considered safe by sex workers. Similar perception was prevailing among clients who thought well-dressed men and clean women were safe. Thus, the major lesson is learnt about clean men / women myth prevailing among sex workers and their clients. Specific messages to dispel these myths were initiated in the state to increase the condom usage by sex workers among regular partners

In addition to school-based intervention programmes, YRG CARE also conducts industrial interventions. YRG CARE trainers have made presentations in 30 industries within Tamil Nadu since 2002, following a top-down approach that seeks to reach employees at all levels.

Since its founding in 1993, YRG CARE has greatly expanded its efforts in addressing the important issues surrounding the HIV/AIDS epidemic in India. Even as much emphasis has been placed in recent years upon the development of care and research programmes and facilities, prevention-oriented programmes continue to be an important part of YRG CARE's commitment to fight HIV/AIDS.

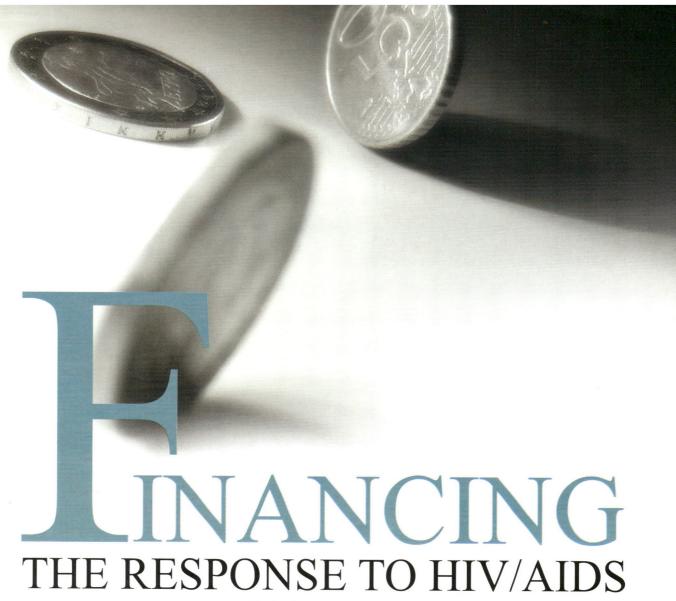
Summary:

The large number of players contributed to a very active preventive program in Tamilnadu. TANSACS and APAC played the key role of developing and encouraging partnership. The strategy of focusing on high risk group has been very effective. Even though the coverage of high risk groups is in the range of only 60%, the strategy has played rich dividends and the HIV epidemic has been controlled to a large extent in the state.

However there are some high risk sub-groups who have not had adequate attention. The main weakness identified is that the relatively poor emphasis on the intervention among MSM and transgender groups of the state. The information in the state regarding intravenous drug use also remain a challenge to be addressed further as we move ahead in the National AIDS Control

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S.P. Thyagarajan

Soon after reporting of the first few HIV/AIDS cases in the country in 1986, Government of India set up a high powered National AIDS Committee in the same year and in 1987 launched the National AIDS Control Programme. The Indian Council of Medical Research (ICMR) took the primary responsibility for setting up surveillance units and enhancing the knowledge base on HIV disease in the country. The expenditure incurred in the early phase of the epidemic is given in table. 12 below. It shows that the response to the epidemic received very little support in the early years and the support at national and state levels has increased only after the launch of India's Medium Term Plan for control of HIV/AIDS.

Table 12: ICMR EXPENDITURE FOR HIV/AIDS PROJECTS

Year	India (in lakhs)	Tamil Nadu (in lakhs)
1986-87	48.88	6.30
1987-88	45.51	3.57
1988-89	37.34	3.70
1989-90	30.78	20.40
1990-91	31.42	5.12
1991-92	16.76	7.17

Source: ICMR, New Delhi Data Centre

In 1990, the surveillance data had shown the alarming rise in HIV prevalence among the high risk groups. This necessitated the organized, planned and collaborative response. A medium Term Plan (MTP) 1990-1992 was prepared by the government in cooperation with the WHO with a budget of US\$ 19 Million. It focused on four states namely Tamilnadu, Maharashtra, West Bengal and Manipur and four metropolitian cities of Chennai, Kolkota, Mumbai and Delhi. Under this plan a number of steps were initiated that included targeted IEC campaigns, surveillance and improving management capacities. The other preventive activities like blood safety, STD control and condom promotion began only towards the end of the medium term plan.

The evolution of NACP is described under the chapter on "Organisational development". A well structured HIV/AIDS control activity in Tamilnadu was coordinated through the formation of Tamilnadu State AIDS cell initially and subsequently by the TANSACS. This effort was very effectively supplemented by the USAID funded APAC project.

Study of HIV/AIDS control efforts in Tamil Nadu would need to focus on the two major programs: the government sponsored program of TANSACS funded primarily by GOI funds borrowed through IDA funds of the World Bank and the NGO program of VHS effected through APAC which was funded by bilateral aid from USAID. In addition to these two large source of funds, state funds and private funds also contributed significantly to the early response in Tamilnadu. Noteworthy among them are Christian Medical College, Vellore, University of Madras and Government funded Madras Medical College (MMC).

In later years Tuberculosis Research Centre (ICMR) Chennai; Tamil Nadu Dr. MGR Medical University; besides certain NGOs like TNVHA, ARFI, CAN, YRG-CARE etc who used their funds resourced through funding agencies for HIV/AIDS related work. In addition, these organizations had also obtained funds, for increasing HIV/AIDS awareness, initiating service delivery and conducting research. Some of these funds were from both national agencies like ICMR, DBT and international agencies like BritishODA, US agencies / Universities etc. While the quantum of funds received by these organizations are varied, the outcome of their efforts in HIV/AIDS had contributed to the program and created a positive impact on the overall HIV/AIDS scenario in Tamilnadu.

Other international projects that were operational in Tamilnadu included: the HIV/AIDS Alliance Project, World Vision Project, Population Council Project etc. While the quantum of funding provided

by them is not available, it is reasonably clear that these agencies had brought in substantial funding to support some key activities.

Table 13: PATTERN OF FUND ALLOCATION / UTILIZATION FOR HIV / AIDS CONTROL IN THE STATE (TANSACS & APAC BUDGET) (RS. IN LAKHS)

Years	Budget Allocation	Utilization	Percent Utlization
1987 – 1988			
1988 – 1989			
1989 – 1990			
1991 – 1992			
1992 – 1993	145.42	0.88	0.6%
1993 – 1994	153.26	78.50	51.2%
1994 – 1995	277.44	227.79	82.1%
1995 - 1996	650.00	731.55	112.5%
1996 – 1997	1743.94	1329.34	76.2%
1997 – 1998	2000.00	1672.90	83.6%
1998 – 1999	1595.13	1383.89	86.8%
1999 – 2000	1571.99	1408.27	89.6%
2000 - 2001	1000.00	771.75	77.2%
2001 – 2002	1300.88	1624.26	124.9%
2002 - 2003	1500.67	1349.15	90.0%
2003 - 2004	1708.35	1215.28	71.1%

A quick look at the pattern of fund allocation and utilization as given in Table. 13 indicates the evolution of the state level response. Percentage utilization in the early phase during 1993 and 1994 is relatively low (0.6% and 51.2%) as compared to later years 2002 & 2003 (124.9%, 90.0%). This was probably due to the difficulties faced by the program managers in getting a buy-in from the senior management and obtaining financial clearances for HIV/AIDS activities. The society model initiated by the Government of Tamilnadu proved to be an excellent innovation and facilitated the establishment of efficient financial management mechanisms during the later years of NACP I. The model has been adopted by the GOI for NACP II and replicated the society model in the form of State AIDS Control Societies (SACS) in all states and union territories.

Percentage utilization of funds in Tamilnadu as shown in Table 2 indicates that the state was making use of all available funds provided under the program and also reflects the efficiency of the system in the state. This also demonstrates the quality of the leadership and the success of sensitization efforts made among the community regarding the problem of HIV/AIDS in Tamilnadu.

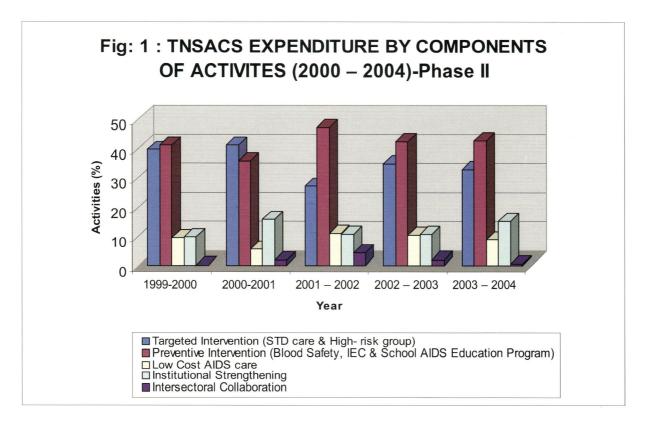
Table 14: TNSACS EXPENDITURE BY COMPONENTS OF ACTIVITES (2000 2004)

S. No.	Activities	1999- 2000 (%)	2000- 2001 (%)	2001- 2002 (%)	2002- 2003 (%)	2003- 2004 (%)
1	Targeted Intervention (STD care & High- risk group)	39.64	41.22	27.06	34.74	32.87
2	Preventive Intervention (Blood Safety, IEC & School AIDS Education Promotion	41.14	35.76	47.08	42.44	42.62
3	Low Cost AIDS care	9.42	5.46	11.02	10.12	8.80
4	Institutional Strengthening	9.64	15.47	10.69	10.72	15.03
5	Intersectoral Collaboration	0	1.82	4.05	1.88	0.42

Table 15: NUMBER OF NGOS FINANCED BY THE PROJECT IN SELECTED STATES AND BY NACO, 1993-1999

State	1993-94	1994-	1995-	1996-	1997-	1998-
		1995	1996	1997	1998	1999
Andhra	0	0	0	9	34	0
Pradesh						
Delhi	0	0	0	8	4	1
Maharashtra	6	10	20	16	97	32
Tamil Nadu	0	17	22	63	88	106
Uttra Pradesh	0	0	3	8	13	0
West Bengal	0	5	6	10	10	10
NACO (b)	0	0	6	20	47	8

Table 14,15 above and figure 24 below show the program priorities of the Tamilnadu state and the sustained emphasis on prevention related activities in particular among the high risk groups. Under NACP II from 1994 onwards Tamilnadu stood out as the state with the largest number of targeted interventions in the country while other states were still focusing on IEC as the main strategy. Figure below showing utilization of funds also demonstrates the emphasis on Targeted interventions brought about by the combined efforts of TANSACS and APAC project.



Socio-economic impact analysis of HIV/AIDS:

The economic impact of the disease can be broadly classified into (i) Macroeconomic effects dealing with sectoral effects and (ii) Microeconomic effects dealing with families and individuals. To take the last one first, the impact of a major shock to the household system emanating from the event of one or more household members falling sick or dying, will be felt on all fronts of the household economy. The greater the number of members sick/dying/dead, the greater the economic impact on the household. This impact will be felt in obvious ways on income, productivity, consumption, employment, health and non-health expenditures, schooling of children, health of other members of the household, asset holdings, and so on.

There have been several studies around the world particularly in Africa that have demonstrated the severity of HIV/AIDS impact. In Botswana, a study calculated that household income in the poorest quarter of households was likely to fall by 13% because of HIV/AIDS (USAID, 2002)¹. Another study (World Bank 1997)² indicated that people with AIDS were more likely to seek medical care and incur out-of-pocket expenses than people who died of other causes. In Thailand, one-third of rural families experienced a halving of their agricultural output, and another 15% had to remove their children from school.

Finally, these micro and sectoral impacts can, and do, translate into macro effects on the economy, affecting parameters like growth, national income, employment, productivity etc. It is clear now that a severe epidemic can reverse the growth and development process in developing countries, as has happened in sub-Saharan Africa. A very recent study of nine countries in the Middle East and North Africa indicates that on an average, GDP losses across countries for 2000-2025 could approximate

35% of the current GDP. In all countries it is possible to observe scenarios where losses surpass current GDP (Jenkins et al.2002). There is as yet no comprehensive study on India that attempts to quantify the effects of the HIV/AIDS epidemic on growth and income in a general equilibrium framework.

An analysis of expenditure on AIDS control **Program in Tamilnadu**

There is insufficient information at this juncture to perform a full economic analysis of the program in Tamilnadu. Though there is reasonably good data set on the expenditure side, there is very little information on the cases averted and or Disability Adjusted Life Years Saved which are essential components of this analysis. Even on the expenditure side only direct cost of the provider/government was available. Information on indirect costs (especially wages foregone as a result of illness and hospitalization) are difficult to asertain. Based on a review of the available literature on economic analysis in India on HIV /AIDS in Tamilnadu, the literature showed that there were 2 case studies which looked at macro and micro-economic impact of HIV/AIDS in India.

In the first study, Duraisamy et al. (2004) looked at 'Costs and Financial Burden of Care and support Services to PLHA and Households in South India, the objective of this study is to estimate the medical and non-medical out-of-pocket expenditure on care and support services to PLHA, the financial burden on households, the indirect costs and coping strategies to meet the financial burden. A structured pre-tested questionnaire was used to collect data from a cohort of 153 clients of YRG CARE, a leading Chennai based NGO, who had completed the first and third waves of interview during 2000/2001 and 2001/2002 respectively.

The results show that the median out of pocket medical and non-medical expenditure (direct cost) for treatment and services are Rs.6,000 (US \$ 122) in a reference period of six months. Clients on antiretroviral (ARV) drugs spend five times more than those not on ARV. The median direct cost significantly increases with stage of disease, household income, and poverty level. The financial burden of treatment, measured as the ratio direct cost to household income, is greater for lower income (82%) than on higher income (28%) households. 31% and 45% of the clients reported loss of income and workdays respectively.

In conclusion the direct costs and financial burden of care and support services increase with the stage of disease. The financial burden is disproportionately more on low-income households. HIV/AIDS leads to depletion of saving and increases the indebtedness of households.

In the second study, Ganesh AK et al. (2004) analysed the 'Impact of falling costs of antiretroviral therapy on VCT services: Experience from South India'. This study was undertaken to study the impact of HAART usage on VCT services in the context of falling cost of ARV in Chennai. Analysis was done to study the trend between the increasing number of clients attending the VCT centre and the number of HIV infected patients accessing ARVs between Jan 1996 and December 2003 & in December 2004.

From January 1996 to December 2003, 8523 individuals have accessed the VCT services and 5146 patients received medical care. Among individuals who required HAART in 1996, 3.4% received

Future
Directions for
Controlling
the HIV
Epidemic

S.P. Thyagarajan & Kurien Thomas

uture directions for Tamilnadu and for India must be based on the lessons learned from the program since 1986. The valuable experience must be dissected to understand the strengths and weaknesses of the program. Even though at the current level of interventions the epidemic is showing a down ward trend, there is no room for complacency. The battle is not won. There is a great deal of success but it is an unfinished agenda. The following suggestions are preliminary and need to be considered by the large group of stake holders in Tamilnadu as we move ahead.

HAART. In 2003 this trend has increased to 35% and to 50% in 2004. The cost of HAART in 1996 in India was 800USD/ month and in 2003, it was 30 USD/ month and in 2004 it was 20 USD/ month.

The increased utilization of VCT services may be attributable to the availability of affordable, generic HAART and access to continuum of care. HIV patients are more likely to seek testing if they believe that they will have access to affordable therapy.

Discussion on Cost and Effect on HIV/AIDS:

The early predictions of Gloom in 1998 at the start of NACP II with the Tamilnadu state having more than 5% prevalence in a short span of 5 years were disproved. There is a need to understand Tamilnadu response in comparison to other success stories at the global level in the fight against HIV/AIDS. In United States the problem has been largely contained within the high risk community of MSM and in Australia among Intravenous Drug Users. In most developing countries of Africa and Asia, the main mode of transmission is heterosexual. Thailand, Brazil and Uganda have also demonstrated reversal of the heterosexual epidemic.

In the Indian context, Tamilnadu with a population of 70 million which is comparable to countries like Thailand or Uganda. Even though it is the only state in the country which has demonstrated epidemiological reversal, the program has achieved this with relatively smaller inputs as compared to other global examples.

It must be understood that even though the spread of the virus has been reduced in the state, the socio-economic impact to the economy due to the already infected individuals is likely to continue or increase for a longer time particularly in the area of care, support and mitigation. These can be addressed in many ways but each has its own resource constraint. It is important therefore to continue the emphasis on prevention while harnessing additional resources for care, support activities as the best way forward to arrest the spread of the disease and reduce the impact on society.

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Coverage of High Risk Groups in Tamilnadu:

- ◆ The strategy on focusing on HRG has yielded rich dividends and shown that the spread of the epidemic can be arrested and reversed in India more efficiently than in many other parts of the world. However at current levels of 50% coverage of high risk groups need to be up scaled to reach 80%-90% with saturation of HIV related services of condom, access to screening and treatment of STD and Behavioral Change communication repeated regularly to make every sexual act protected.
- ◆ There is need for greater focus on MSM particularly male sex workers and IDU groups who pose a special threat in the future. A comprehensive package of quality prevention services that includes outreach, needle syringe exchange, condoms, VCCT, STD management, drug substitution and referrals for health care as well as drug treatment should be made available for the majority of IDUs. In addition, given the transmission potential to non-injecting wives and regular sex partners of IDUs, the interventions need to reach out to them and provide services that include counselling, VCCT, condoms, STI identification and treatment. As many drug users are incarcerated, IDU interventions have to be implemented in prison settings also.

Interventions in other vulnerable groups:

- Truckers, Factory workers migrants, out of school children are all at increased vulnerability to the HIV epidemic. While the condom use in non-regular partners is very high. There is need to increase the condom use in casual sex within regular partners. This is a tall order and requires attention in terms of effective BCC and Inter-personnel communication targeting vulnerable populations
- ◆ There is a great deal of success in the interventions among youth particularly school AIDS program with coverage of nearly 100% of government schools in the state. However out of school youth remain a vulnerable target who require special attention in the future. Partnership has to be built with different partners to initiate interventions in this group.

STD Treatment:

- Access to STD care is very poor in the state. Only 3-4 people access to STD care at the district level at each STD clinic. Making RTI and STD care available through a large number of preferred private providers for all vulnerable population nearer to their place of residence is important for control of STD in the community.
- ◆ The STI management in high risk groups need to be enhanced. The TI programs will need to include screening for STI in HRG as a specific policy so that the most vulnerable are adequately identified and treated.
- ◆ Drug resistance to bacterial STD can pose a threat to syndromic management. The guide lines have to be tuned based on information generated on anti-microbial resistance generated regularly from the state reference laboratories.
- ◆ There is need to initiate greater number of workplace and migrant workers interactions so that industrial workers in factories and migrant workers in the informal sectors can be targeted for prevention, care and support.

Condom Promotion:

◆ The condom sales in the state is relatively high with 36 million condoms made available through wide variety of outlets including fair prize shops. However the contribution of social marketing is very low. This needs to be addressed through increased awareness campaign and BCC and setting up institutional arrangements to facilitate different brands to be available to cover all sexual acts in the state.

Care, support and Treatment:

- One of the greatest weakness of the program in the state is that only a small fraction of infected people are aware of their diagnosis. This prevents access to prevention and care and support activities to be initiated in this group. There is urgent need to scale up the Counseling and Testing services so that vulnerable population and HRG can have testing done in confidence nearer to the in place of residence.
- ◆ The strides made in care and support by different groups in Tamilnadu is commendable. Govt. Thoracic Medicine Hospital (GHTM) at Tambaram has become to focus point for best practices in care and support. Christian Medical College and YRG care are in forefront of showing optimum ways of providing care and support in the country. However there is need to scale up the care and support to involve a much larger number of institutions in the state both in public sector and private sector.
- Considerable proportion of IDUs have HIV with hepatitis C co-infection and it is important to bring the benefit of anti retroviral treatment to the injecting drug users, in particular, those with coinfection.
- ♦ Stigma and discrimination still remains a problem for the state and more efforts are needed at State, District and Community level to tackle this problem.
- Drug resistance to ARV may be a major issue unless the following are implemented
 - 1. Continuous supply chain of ARV is ensured
 - Proper Adherence counseling is done
 - 3. Ban on OTC supply of ARV
 - 4. Training of HCW in the ART roll out centres.

Building Capacity in the HIV community:

- ♦ One of the most crucial areas of success in TN has been the partnership of wide group of stake holders. If the activities have to be scaled up to obtain 80% coverage, the partnership efforts need to be doubled over a short time span.
- ◆ PLHA networks and NGO networks are stronger in Tamilnadu than in many other parts of the country. However the capacity need to be built further so that ownership of programs running prevention and care and support has to be taken over by the CBOs over the next few years.
- ♦ Nearly 4 lacks of HIV positive people in the state continue to be a source of infection. More focused effort of linking prevention with care and support and strengthening the PLHA groups to participate in positive living is crucial for the success of the future program.

"MARCHING TOWARDS THE 150th YEAR OF



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stablished in 1857 as one of the first three Universities in modern India on the model of London University along with the Universities of Calcutta and Mumbai, the University of Madras has 150 years glory of yeomen international contributions to higher education with innumerables prestigious alumni in areas of Science, Technology, Humanities, Social Sciences, Languages, Public Life, besides National and International governance. The facts that Dr. Sir C.V. Raman and Dr. C.V. Chandrasekar as nobel laureates and Six Presidents of India namely Sarvapalli Dr. S. Radhakrishnan, Shri V.V. Giri, Shri Neelam Sanjeevi Reddy, Shri R. Venkataraman, Shri K.R. Narayanan and Dr. A.P.J. Abdul Kalam are distinguished alumni of the University of Madras are just the tip of the pyramid of Her academic glory.

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- 1. Inauguration of SENATE HOUSE July 2006.
- 2. National Celebration of "150th Year of Indian Higher Education".
- 3. 150th Foundation Day 5th September 2006.
- 4. Joint Celebrations with Universities of Calcutta & Mumbai
- 5. Bimonthly International Conferences.
- 6. Monthly National Seminars/ Symposia/ Workshops by each Department.
- 7. Launch of "Centres of Excellence" at the University.
- 8. Establishing Endowment Chairs / Professorships.
- 9. Cultural Festival UNIFEST-2006.
- 10. Sports Festival.
- 11. 150th Year Convocation 5th September 2007.

This INCLEN Documentation project on "Tamilnadu Response to HIV/AIDS: 1986 2005" co-ordinated by University of Madras is a previlege contribution in the area of Biomedical Sciences.

Prof. S.P. THYAGARAJAN

Vice-Chancellor, University of Madras







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