HEALTH AND FAMILY WELFARE DEPARTMENT

3.2 National AIDS Control Programme

The National AIDS Control Programme was introduced in 1987 for countrywide implementation. The main objective of the Programme was not fulfilled in the State due to lack of effective planning, inadequate infrastructure as well as inadequate laboratory testing facilities, shortage of laboratory technicians, and non-availability of medicines for treatment. The performance of the intervention projects suffered due to non-formulation of viable projects according to the core principles of the programme.

Highlights

Against the funds of Rs. 4.29 crore available during 1998-2003 for implementation, Rs. 1.11 crore (26 *per cent*) remained unspent as of March 2003.

(Paragraph 3.2.5)

The drug de-addiction centre at Kumarghat established at a cost of Rs. 8 lakh in September 2000 for providing treatment to injecting drug users could not be made operational for want of equipment, medicines and technical staff, as of May 2003.

(Paragraph 3.2.9)

The intervention projects were not formulated according to the core principles of the programme as many important components were excluded and the prescribed cost schedule for the components of the project were not followed. The expenditure of Rs. 21.22 lakh incurred on them during 2000-03 proved largely wasteful.

(Paragraph 3.2.10)

Infected persons were not informed of their HIV infection. As a result, 278 such persons in the State, as of March 2003, had been unknowingly spreading the deadly disease among the State population. Moreover, as appropriate method of testing was not being followed, blood units supplied from blood banks were also not considered fully safe against HIV infection.

(Paragraph 3.2.15)

Training of medical and paramedical staff in AIDS management was to be completed by March 2002. But 85 *per cent* of the staff targeted for training were not trained as of March 2003.

(Paragraph 3.2.18)

Introduction

3.2.1 Acquired Immuno-Deficiency Syndrome (AIDS) is a life threatening condition representing the most serious public health problem in India. The infection is caused by a virus called human immuno-deficiency virus (HIV). According to the report titled 'Combating HIV/AIDS in India, 1999-2000' brought by the National AIDS Control Organisation (NACO), the predominant modes of transmission of infection in AIDS patients is through heterosexual contact (80.86 *per cent*) followed by blood transfusion and blood product infusion (5.52 *per cent*), injecting drug users (IDU) (5.30 *per cent*), perinatal transmission (0.72 *per cent*) and others (7.60 *per cent*). To combat HIV/AIDS, the Government of India (GOI) launched National AIDS Control Programme in 1987. The programme has moved through three phases since its launching. The GOI negotiated with the World Bank and the International Development Association (IDA) to support a full-fledged National AIDS Control Project (NACP-I covering the period 1992-99 and NACP-II covering the period 1999-2004).

Objectives

3.2.2 The key objectives of the programme were to reduce the spread of HIV and to strengthen India's capacity to respond to the HIV/AIDS on a long term basis. The goal of National Health Policy 2002 was to achieve zero level growth of HIV/AIDS by 2007. The following components were implemented in the State to achieve the objectives and goal of the programme:

(a) Priority targeted interventions for groups at high risk;
(b) Preventive intervention for general community; and
(c) Institutional strengthening

The other two components – Low Cost AIDS Care and Intersectoral Collaboration were not implemented in the State.

Organisational set up

3.2.3 The programme was implemented by the Programme Officer of the State AIDS Cell up to 1998-99 and thereafter by the Project Director of State AIDS Control Society (hereinafter called the Society) through four Chief Medical Officers (CMOs) of all the four districts, four Medical Superintendents of State and District Hospitals[*], 10 Sub-Divisional Medical Officers, nine Rural Hospitals, 61 Primary Health Centres (PHCs) and 19 Non-Governmental Organisations (NGOs). The Society had the Commissioner-cum-Secretary of the Health and Family Welfare Department as its President up to 27 February 2001 and thereafter Minister of Health and Family Welfare as Chairman with 10 members including the Project Director as the Member-Secretary. The Project Director and the Assistant Project Director of the Society were on deputation from the department. The Society

[*] Two State hospitals: GB hospital and IGM hospital (both at Agartala); two district hospitals:Tripura Sundari (TS) hospital at Udaipur, and Rajib Gandhi Memorial (RGM) hospital at Kailashahar.

had 20 other staff members all of whom were on contract service (since April 2001) renewable from time to time.

Audit coverage

3.2.4 Implementation of the programme for the period from 1998-99 to 2002-03 was reviewed in audit between January and April 2003 based on test-check of records of the Society♣, all the four CMOs, all the two State hospitals♥, two District hospitals] out of four, three Sub-Divisional hospitals∫ out of 10, two Rural hospitals(out of nine, seven PHCs♦ out of 61 and six NGOs out of 19, covering an expenditure of Rs. 1.19 crore (37 *per cent*) out of Rs.3.18 crore. The results of audit are discussed in the succeeding paragraphs.

Financial arrangement

3.2.5 National AIDS Control Programme is a 100 *per cent* Centrally sponsored scheme financed by Government of India up to 1998-99 and thereafter by National AIDS Control Organisation (NACO). Grants are directly to be released to the Society only after its annual action plan is approved by NACO. Subsequent release of grants was to be on the basis of actual expenditure reported by the Society and expenditure likely to be incurred during the year. Grants released by the Government of India/National AIDS Control Organisation during 1998-2003 and expenditure thereagainst are shown below:

(Rupees in crore)

Year	Opening balance	Funds released	Actual expenditure	Closing balance
1998-99	0.20	NIL	0.20	0.00
1999-2000	0.00	0.70	0.37	0.33
2000-01	0.33	0.82	0.75	0.40
2001-02	0.40	1.92	1.29	1.03
2002-03	1.03	0.65	0.57	1.11
Total		**4.09**	**3.18**	

Source : Information furnished by Tripura AIDS Control Society.

Against the funds of Rs. 4.29 crore (including opening balance of Rs. 0.20 crore) available, the agency utilised Rs. 3.18 crore during 1998-2003, leaving an unspent balance of Rs. 1.11 crore (26 *per cent*). An amount of Rs. 0.68 crore, though sanctioned by the Government of India during 1998-99, was not released due to delay in formation of the State AIDS Control Society.

♣ The State Aids Control Society (SACS) is audited under Section 14 of the Comptroller & Auditor General's (Duties,Power and Conditions of Service) Act, 1971.

♥ GB Hospital and IGM Hospital, both located at Agartala.

] TS Hospital, Udaipur and RGM Hospital, Kailashahar.

∫ Bishalgarh, Kamalpur and Dharmanagar.

(Kumarghat and Jirania.

♦ Narsingarh, Mohanpur, Madhupur, Kakraban, Fatikroy, Panisagar and Kadamtala.

An amount of Rs. 17.58 lakh was advanced (February 2002) to four CMOs[–] to make arrangement for conducting awareness campaigns through the local bodies like Nagar Panchayats, Gram Panchayats, and Agartala Municipal Council. The local bodies were duly paid the amount by the CMOs. The vouchers for adjustment of Rs. 17.58 lakh had not yet been received by the Society. The vouchers were also not made available to Audit by the CMOs during test-check. As such, expenditure of Rs. 17.58 lakh on awareness campaign could not be verified in audit.

Infrastructure

3.2.6 The State Government was required to provide infrastructure with adequate equipment and trained personnel in various health institutions for quality health services. The target fixed for creation of infrastructure and achievement thereagainst during 1998-2003 are shown below:

Name of the units	Target	Achievement	Percentage of shortfall
Blood banks	6	6	NIL
STD clinics	11	3	73
Sentinel surveillance centres	5	3	40
Voluntary blood testing centres	3	1	67
Zonal blood testing centres	3	1	67
Blood component separation unit	1	NIL	100

The Government attributed (August 2003) the reasons for shortfall to lack of planning of the concerned officials of the Society and shortage of manpower.

Blood Banks

3.2.7 It is the responsibility of the State Government as well as the State AIDS Control Society to provide the latest technology available for blood transfusion services and ensure its functioning in an updated manner. The Department claimed to have modernised all the six blood banks in the State. But it was noticed that against 40 items of equipment required to be provided in a modern blood bank, items ranging from four to 12[(] only were provided in these six blood banks. One Elisa reader machine without printer was provided to BSM hospital, Kamalpur, in September 2001. As a result, the Elisa system remained inoperative (May 2003). The blood bank of TS hospital needed repairs and renovations for which an estimate of Rs. 0.94 lakh was sent to the Society in February 2000. But it was noticed that the said work had not yet been taken up as the Society did not provide the required funds (May 2003).

Again, against the requirement of 24 Laboratory Technicians, 12 Laboratory Assistants and 12 Nurses for six blood banks (according to in-charges of the blood banks), only 12 Laboratory Technicians and five Nurses were provided. It was also noticed that against six technicians required to be appointed by the

[–] CMO (West): Rs. 7.02 lakh; CMO (South): Rs. 5.23 lakh; CMO (North): Rs. 3.28 lakh; and CMO (Dhalai): Rs. 2.05 lakh.

[(] Four items in RGM hospital and 12 items in GB hospital, IGM Hospital, TS hospital, BSM hospital (Kamalpur), and Dharmanagar hospital.

Society, for which grants of Rs. 0.75 lakh per blood bank per year were available under the programme, no technician was yet appointed. The reasons for not appointing technicians could not be stated by the Society (May 2003).

The Government replied (August 2003) that required number of Laboratory Technicians and Assistants were provided by Health and Family Welfare Department. The reply is not tenable as there was nothing on record to show that the requirement was even assessed by the Society.

Blood Component Separation Unit

3.2.8 According to the National Blood Policy, only the components of blood which are required by a patient should be transfused. For rational use of blood, its components and plasma fraction, it was envisaged in the programme that blood component separation facilities would be established in all the modern blood banks.

Against the requirement of six blood component separation units for the blood banks already set up, it was seen that even the infrastructure for one such unit though targeted to be set up in 1996-97 for the blood bank of the GB hospital, was not provided as of March 2003. For blood component separation facilities, equipment supplied by the NACO (through supplying agency) between March 2001 and July 2002, value for which could not be stated by the department though asked for, had been lying idle (July 2003). The items of equipment were not installed and their functioning tested though the warranty period of one year for most of its components was over. The Government attributed (August 2003) the reasons for delay to failure of the supplier to provide a critical component from NACO 'in due time'.

Drug De-addiction Centre

3.2.9 For providing treatment to the injecting drug users (IDUs), one drug de-addiction centre was established at Kumarghat at a cost of Rs. 8 lakh, and the centre was inaugurated by the Health Minister in September 2000. But the centre was still not functioning, as of May 2003, for want of equipment, medicines and technical staff. The Government stated that the centre should not have been inaugurated before availability of staff.

Programme Implementation

Priority targeted intervention for groups at high risk

3.2.10 Intervention with people with increased vulnerability to HIV is one of the core strategies for prevention of HIV in India. The project aimed to reduce the spread of HIV among groups at high risk by identifying target population and providing peer counselling and condom promotion. These were to be largely delivered by NGOs. The amount allocated for each high-risk group and the expenditure incurred in intervention projects during 2000-03 are shown in **Appendix - XV**.

It was noticed that against the cost of Rs. 1.49 crore as per scales of estimates prescribed in the NACO guidelines, 20 intervention projects at a total cost of Rs. 34.79 lakh only were sanctioned and taken up during 2000-03. The basis of fixing the cost of the projects by the Society was not made available to Audit. Whether the projects, each of which was to be implemented at such a low budget, were at all viable was not examined while fixing the cost of the different projects.

For successful implementation, the intervention projects should include all the following components (i) programme management, (ii) behaviour change communication, (iii) cost of service, (iv) enabling environment, and (v) monitoring and evaluation. It is not enough to provide only one component or its sub-component for a sustainable result.

According to the core principles of the programme, the NGOs whose proposals were recommended by the Technical Advisory Committee, were to be invited to undergo a short orientation course of training in understanding the principles of interventions and formulating a viable project. Seven projects (2000-01 to 2001-02) test-checked, indicated that all of the above components were not covered by the projects and the NGOs were not invited to participate in short orientation course of training. The projects included only cost of programme management and honoraria for counsellors and the medical officer. The Government admitted (August 2003) that the Society made mistakes in formulating the projects.

The honorarium admissible as per scale prescribed by the NACO and the honorarium allowed by the Society in fixing the cost of programme management of the project are shown in the table below:

Category of staff	Monthly rate of honorarium prescribed by NACO	Monthly rate of honorarium allowed by the Society
Programme coordinator	Rs. 6000	Rs. 1500
Office support staff	Rs. 3000	Rs. 300-500
Counsellor	Rs. 4000	Rs. 300-1000
Part time doctor	Rs. 4000	Rs. 500

It was also noticed that cost of drugs for treatment, cost of community events for behaviour change, cost of creating enabling environment and evaluation of the programme were not taken into account. As no viable projects were formulated to achieve the objectives of intervention, the expenditure of Rs. 21.22 lakh incurred during 2000-03, proved wasteful. The performance of a few NGO projects is discussed below.

(i) Door of Hope

3.2.11 An intervention project of 105 Injecting Drug Users (IDUs) was sanctioned (April 2001) for Rs. 3.53 lakh (for three years) against the cost of Rs. 5.84 lakh as per scales prescribed by the NACO and Rs. 1.21 lakh was released to the NGO between July 2001 and March 2002 without making operational the Drug De-addiction Centre, at Kumarghat where the IDUs were

to be treated. The project did not include cost of remuneration to staff, creation of enabling environment and evaluation.

It was seen from the performance report furnished by the NGO that though 70 *per cent* of the IDUs were motivated to undergo treatment, the facilities for treatment could not be provided by the Society to the IDUs, despite repeated persuasion from the NGO. The NGO requested (November 2002) to discontinue the project as it was meaningless to continue the project without medical services for de-addiction. The Department decided (January 2003) to discontinue the project. Thus, the project without any provision for treatment did not serve any purpose and the expenditure of Rs.1.16 lakh incurred up to August 2002 towards wages of field workers, stationery, contingent expenditure, transportation and workshop had gone waste.

The Government stated (August 2003) that the funds could have been released to the NGO only after availability of staff in the Drug De-addiction Centre.

(ii) Sanghadip

3.2.12 A project for 1800 truck drivers was taken up in April 2001 at a total cost of Rs. 2.30 lakh (for three years) against the cost of Rs. 10.40 lakh as per scales prescribed by the NACO. Scrutiny of the activity reports submitted by the NGO revealed that routine nature reports indicating health check up of drivers ranging from 105 to 250, and counselling of drivers ranging from 1080 to 1754 were furnished without any further details as to how and by whom health check up and counselling were done.

Behaviour change communication, and creation of enabling environment are the core principles of targeted intervention. For this purpose, baseline assessment at the end of the year is required to be conducted to evaluate the programme. But it was noticed that these components were ignored and no funds were provided for them. All these factors together made the project ineffective.

(iii) Lions Club

3.2.13 An intervention project for two years for 3210 migrant labourers working in the brick fields for Rs. 5.70 lakh was sanctioned in January 2001 against the cost of Rs. 15.58 lakh, as per scales prescribed by the NACO, and Rs. 2.56 lakh was released between April 2001 and January 2002.

The six monthly activity reports submitted by the NGO indicated that 14 health camps and 349 group discussions were held during the year 2001 covering 1125 labourers, and 5000 condoms were distributed. It was also noticed that the project was discontinued since January 2002.

The Government stated (August 2003) that, as the performance of the NGO was not satisfactory, the project was discontinued. Thus, the objectives of the project intervention remained largely unachieved.

Control of Sexually Transmitted Diseases (STD)

3.2.14 With the arrival / spread of HIV infection and because of its strong relation with STD, National STD Control Programme was brought under the

purview of the NACO since 1992 and STD clinics were sought to be strengthened by providing drugs, consumables and laboratory support for diagnosis and treatment. All the three STD clinics in the State were claimed to have been strengthened by the department, which meant that the clinics should have had the above facilities.

Test-check revealed that neither any trained Laboratory Technicians nor any Laboratory Assistants were provided in two STD clinics at the TS Hospital, Udaipur, and the RGM Hospital, Kailashahar. Laboratory facilities like reagent, kits, equipment for diagnosis and medicines for treatment were not provided in these STD clinics. In the RGM hospital, Specialist (Dermatology) was also not available since inception to run the clinic effectively as of May 2003.

Records of STD clinic at the GB Hospital indicated that against the requirement♠ of 640 vials of Penicillin, 58200 capsules/tablets of Tetracycline, 43120 of Erythromycine, 7540 of Cotrimoxazole and 4524 of Ciprofloxacin for 1056 patients (actually treated) suffering from Syphilis, Gonorrhoea, Chancroid and Lympho Granuloma Venerae (LGV) during 1998-2002, only 550 vials of Penicillin, 500 tablets/ capsules of Tetracycline and 3400 of Ciprofloxacin were supplied to the clinic. It was also noticed that, for treatment of the diseases like Herpes Trichonomoniais, Candidiasis and Veneral Warts, no medicines were supplied by the Society though a large number of such patients were detected and the Society was required to supply all the medicines according to the programme.

Family Health Awareness Campaigns (FHACs) were organised in April and December 1999, June 2000, April 2001 and March 2002, by organising camps at sub-centre level and arranging treatment of STD patients. Records of the CMOs of four districts test-checked, indicated poor performance in the campaigns organised between June 2000 and March 2002 as shown below:

Period	Target population estimated by the Department	Actual attendance in camps	STD patients identified and referred to clinics	Patients who actually attended clinics	STD prevalence rate among the population that attended the camps (per thousand) (Col 5 ÷ Col 3 X 1000)
1	2	3	4	5	6
June 2000	13.94 lakh	96,973(7)	15,159	8,582(57)	156
April 2001	15.58 lakh	1,09,731(7)	16,818	8,415(50)	153
March 2002	15.66 lakh	1,13,575(7)	20,242	9,303(46)	178
Total			**52,219**	**26,300(50)**	

Figures within brackets represent percentage of attendance to the target.

Source: Reports submitted by the Society to NACO.

The above table indicated that had the attendance in camps been larger, the number of STD patients would have been higher than that of the cases identified. It was noticed that the STD patients covered by treatment ranged between 46 and 57 *per cent* during the period. The prevalence rate of STD

♠ The requirement is assessed with reference to treatment schedule and number of patient treated.

ranged from 153 to 178 among the population that attended the camps, which was quite high. Also, about 50 *per cent* of the patients identified remained unprotected against the spread of HIV, despite an expenditure of Rs. 54.15 lakh in the campaigns. The department thus failed in its role in counselling and motivating the STD patients for taking up the prescribed course of treatment.

Stock register of medicines maintained by the CMO, West, and the CMO, Dhalai, showed that STD medicines were not received between March 1999 and June 2000 by the CMO, West, and between February 2000 and April 2001 by the CMO, Dhalai. In the absence of specific medicines, manner in which the programme was implemented could not be clarified by the CMOs. However, records of the AIDS Control Society indicated that various STD medicines worth Rs. 8.51 lakh< as shown in **Appendix - XVI** were supplied between February 2000 and March 2001 but these were not received by the CMOs.

In reply, the Government stated (August 2003) that this was a very serious matter and the Project Director of the Society was asked to investigate.

Preventive intervention for general community

Blood Safety

3.2.15 One of the main objectives of the National Blood Policy is to make the latest technology available to ensure its functioning in an updated manner. The practice of replacement donors was to be phased out to achieve 100 *per cent* voluntary blood donation. And for this purpose, as envisaged, an action plan is required to be developed by the State Blood Transfusion Council. Donor Organiser and Donor Recruitment Officer for all blood banks are required to be appointed and provided with orientation training cum advocacy programme on donor motivation.

Records indicated that neither was any action plan for phasing out replacement donors drawn nor any Donor Organiser♠ or Donor Recruitment Officer♠ appointed by State Blood Council.

The Project Director stated (March 2003) that National Action Plan to achieve availability of 95 *per cent* of the requirement by voluntary blood donation within 2007 was being followed in the State. The reply is not convincing as the State Blood Transfusion Council had achieved 17 *per cent* voluntary donation in 1999, which increased only to 35 *per cent* in 2002. The pace was too slow to successfully attain the goal within another five years when there was no required manpower and a specific action plan.

Records of all the six blood banks, and the zonal blood testing centre indicated that 88,255 blood units were tested between 1998-99 and 2002-03, against

---

< The value of the medicines was calculated on the basis of the rates collected from the local market as these could not be supplied by the Society.

♠ The responsibilities of the holder of the post are to motivate the public for voluntary blood donation and to organise blood donation camps.

which 247 HIV seropositive cases[κ] were detected. The information had been withheld from the infected persons and no counselling was done. Even the HIV positive donors were not informed about their HIV status. Public health experts of the country expressed concern that the HIV positive donors have been living without knowledge of their infection and possibly transmitting it to their sexual partners. This was not conducive to programme objectives. Against this background, in December 2002, the Government of India decided that the blood donors found to be HIV positive would be informed about the status of HIV testing and asked to seek confirmatory test and counselling. But the infected persons had not been informed of their HIV infection as yet (May 2003) and, as a result, 278 HIV infected persons had been unknowingly acting as infecting agents in spreading the deadly disease among the State population.

The Government stated (August 2003) that the matter was taken up with the Government of India and the Society would act according to the Government of India directions.

In blood banks, blood units are screened only by Elisa, rapid and simple (ERS) test. But it was established that on being infected with HIV, it takes about six weeks to six months to develop detectable level of antibody in blood. The time gap is called 'window period'. The infection of blood with HIV is not detectable during the 'window period' by the present system of ERS testing. Therefore, blood units supplied by blood banks of the State for safe transfusion after the units had undergone ERS testing were not to be considered safe, and the chance of infection with HIV remained unchecked.

HIV can be detected even in the 'window period' if blood units are tested by Polymerase Chain Reaction (PCR) method as stated (February 2003) by the Medical Officer in charge of Zonal Blood Testing Centre of GB Hospital. The approximate cost of setting up the PCR testing facilities would be Rs. 10 lakh as per his estimate. But it was noticed that neither the AIDS Control Society nor the State Government was considering the setting up of the PCR testing facilities. The guideline issued by the NACO is also silent about handling the problem of 'window period'.

The Government agreed (August 2003) with the fact pointed out above, and stated that the State Government had been following NACO guidelines only in this regard.

Voluntary testing and couselling

3.2.16 Voluntary testing and counselling is the process by which an individual undergoes counselling enabling him to make an informed choice about being tested for HIV. This would involve increasing demand for the facilities for joint testing of couples. It was envisaged in the programme that one voluntary testing centre would be established in each district. But audit scrutiny revealed that against the target for setting up three centres by 1996-97, only one such centre started functioning in 1999-2000 at the GB Hospital, Agartala.

[κ] In addition, 10 such cases under Voluntary Testing and Counselling and 21 cases by the Sentinel Surveillance Centres were detected.

The performance of the voluntary testing centre is shown below:

Year	No. of sites offering services	No. of volunteers targeted for screening	Attendance per site for individual testing	No. of couples jointly tested	HIV positive cases detected
1999-2000	1	250	105	Nil	01
2000-01	1	250	99	Nil	Nil
2001-02	1	250	78	Nil	02
2002-03	1	250	153	Nil	07

That not a single couple turned up during the years for joint testing was also an indication of poor performance of the awareness campaign taken up by the department.

It was noticed that no Counsellor was appointed and no counselling was done, in spite of availability of grants under the programme towards salaries of two Counsellors. The Government stated (August 2003) that appointment of Cousellors was under consideration of the Society.

Sentinel surveillance

3.2.17 Surveillance of STD patients constitutes an important component of prevention and control of HIV/AIDS. The objective of this activity is to develop an effective surveillance system generating a set of reliable data.

Against the target of five Sentinel Surveillance Centres to be set up by 1998-99, three such centres in three districts were set up at the end of 2002-03. The shortfall was attributed (August 2003) by the Government to non-according of sanction of the new sites by the NACO. Records of the surveillance centres showed that 2236 samples were tested during 1998-2003 against which 21 HIV sero-positive cases were detected.

Training

3.2.18 According to the NACO guidelines, training of all specialists, medical officers, nurses, health workers and all laboratory personnel in AIDS management were to be completed between June 2000 and March 2002. The training was to be conducted locally and the society was to sponsor it.

The targets fixed and achievement thereagainst during April 1999 to March 2003 were as follows:

Category of personnel to be trained	Target	Achievement
Medical Officers including Specialists	1115	410(37)
Nurses	1000	156(16)
Laboratory Technicians	160	6(4)
Paramedical staff	1250	309(25)
Anganwadi Workers	3000	127(4)
Community Health Guides	2400	468(20)
Trained Birth Attendants	1211	Nil(0)
Total:	**10136**	**1476(15)**

Figures within brackets represent percentage of coverage.
Source: Tripura AIDS Control Society.

The table indicates that although the training of all categories of staff was to be completed by March 2002, only 15 *per cent* of the target for 10,136 staff members fixed for the period was achieved up to March 2003. The Society could not explain why 85 *per cent* of staff had not been trained as of March 2003.

Institutional strengthening

Functioning of AIDS Control Society

3.2.19 Tripura AIDS Control Society was formed in August 1998 and started functioning from April 1999. The Society was formed in order to remove the bottlenecks faced by programme implementing officers. But it was noticed that the independent functioning of the Society was not ensured. Funds of Rs. 98.62 lakh were released to the Society during 1999-2003 under "Institutional Strengthening" against which the Society spent Rs. 54.49 lakh only. It was also noticed that against 27 posts sanctioned by the NACO for the Society, eight posts♣ were not filled up, as of March 2003. For field units, 10 posts of Laboratory Technicians for which grants had been available under the programme, were also not filled up. The reasons for delay were not stated although called for (February 2003) in audit.

Monitoring and evaluation

3.2.20 The responsibilities for impact evaluation of the programme rest with National Monitoring and Evaluation Agency. But no such evaluation was so far undertaken by the agency in the State.

Field units are required to submit their monthly reports to the Society in the first week of the following month for monitoring and reporting to the NACO. But it was noticed that 32 reports from the STD clinic of the TS Hospital and 28 reports from the STD clinic of the RGM Hospital were not submitted by the clinics during 2000-01 to 2002-03. The reasons for failure on the part of the Society to collect the reports in time could not be indicated. It was, thus, established that the reports submitted to the NACO did not reflect a correct position of STD treatment during the years.

♣ Dy. Director (STD), Dy. Director (IEC), Dy. Director (Blood Safety), Drug Inspector, Administrative Officer, Monitoring & Evaluation Officer etc.

APPENDIX – XV

(Reference : paragraph 3.2.10)

Statement showing the Intervention Projects implemented during the period from 2000-01 to 2002-03

Group	Year	Targeted interventions		Amount *(Rupees in lakh)*	
		Planned to be covered (*in numbers*)	**Actually covered (*in numbers*)**	**Allocated**	**Utilised**
Commercial sex workers	2001-02	NIL	40	6.00	0.39
	2002-03	NIL	45	6.00	0.54
Injectable drug users	2001-02	NIL	105	6.00	1.21
Truck drivers	2000-01	NIL	92	6.00	1.07
	2001-02	NIL	1800	6.00	2.30
	2002-03	NIL	400	6.00	1.36
Migrant labourers	2000-01	NIL	867	6.00	2.12
	2001-02	NIL	1736	6.00	4.50
	2002-03	NIL	12,394	6.00	4.65
Street children and rickshaw pullers	2002-03	NIL	172	6.00	1.28
Transport workers	2002-03	NIL	3738	6.00	1.80
Total:			**21,389**	**66.00**	**21.22**

APPENDIX – XVI

(Reference: paragraph 3.2.14)

Statement showing the list of medicines supplied by AIDS Control Society but not received by the CMOs

Medicines supplied to Chief Medical Officer, Dhalai District, Ambassa

Name of the medicine supplied	Quantity of medicine supplied during		Value of medicine supplied (Rupees in lakh)
	February and May 2000	March 2001	
Tab Cotrimoxazole	50,000 (Nos.)	20,000 (Nos.)	0.79
Tab Erythromycine (250 mg)	5,000 (Nos.)	16,000 (Nos.)	0.84
Cap Tetracycline (250 mg)	20,000 (Nos.)	1,00,000 (Nos.)	1.44
Tab Metronidazole (400 mg)	25,000 (Nos.)	—	0.17
Tab Norfloxacine (400 mg)	—	10,000 (Nos.)	0.48
Cap Ciprofloxacine (500 mg)	5,000 (Nos.)	15,000 (Nos.)	1.30
Cap Amoxyciline (250mg)	—	10,000 (Nos.)	0.44
Tab Doxycycline (100 mg)	—	18,000 (Nos.)	0.63
B.B. Emulsion (500 ml)	125 (Bottles)	—	0.15
		Total (A)	**6.24**

Medicines supplied to Chief Medical Officer, West District, Agartala

Name of the medicine supplied	Quantity of medicine supplied during February and May 2000	Value of medicine supplied *(Rupees in lakh)*
Tab Cotrimoxazole	50,000 (Nos.)	0.56
Tab Erythromycine (250 mg)	10,000 (Nos.)	0.44
Cap Tetracycline (250 mg)	20,000 (Nos.)	0.24
Tab Metronidazole (400 mg)	35,000 (Nos.)	0.23
Cap Ciprofloxacine (500 mg)	10,000 (Nos.)	0.65
B.B. Emulsion (500 ml)	125 (Bottles)	0.15
	Total (B)	**2.27**

Grand Total (A+B) =Rs. 8.51 lakh