Mainstreaming and Partnerships Working Group for NACP-IV
Minutes of Meeting held May 6-7, 2011 at Parkland Retreat, New Delhi

Table of Contents

Background

India's National AIDS Control Programme is nearing the end of its third phase. Over the last three phases, the Government of India, through the National AIDS Control Organization (NACO) and in partnership with multi-lateral and bi-lateral development partners, civil society and communities affected by AIDS, has made substantial progress towards reducing the incidence of HIV in the general population, in some high-risk groups; and in increasing the proportion of PLHIV who receive care, support and treatment. NACP-IV (2012-2017) aims to consolidate the gains of NACP-III and accelerate reversal of the epidemic and integrate responses across prevention and care, and across sectors.

In April 2011, NACO constituted working groups to assist in joint planning for NACP-IV. Working groups spanned 15 areas covering programs, monitoring, administration and finance[1]. The Mainstreaming and Partnerships (henceforth MaP) working group had its first meeting on April 6-7, 2011.

The purpose of the meeting was to review gains made through mainstreaming and partnerships in NACP-III, identify successes, areas of improvement, areas to be continued, scaled up or dropped in NACP-IV.

Participants

Workshop participants included representatives from government (NACO, Ministries of Railways and Defense), UN agencies (UNAIDS, UNDP, UNICEF, ILO), bi-lateral partners (USAID) and civil society.

NACO
Mayank Agarwal (ex-JD, IEC, now with I& B)
Dr Brijendra Singh
Madhu Sharma
Rajesh Rana
Krishna Kumar

Ministry of Railways
Dr. Rajiv Kumar Jain

Ministry of Defense
Group Capt. Rajesh Vaidya

Ministry of Women and Child Development

[1] See list of working groups and members at http://www.nacoonline.org/NACP-IV/National_AIDS_Control_Programme_Phase_-IV/List_of_Working_Groups/

Dr. Hari Kumar

UN System

Alka Narang	UNDP
Shashi Sudhir	UNDP
Sarita Jadav	UNAIDS
Ivonne Camaroni	UNICEF
Sonia Trikha	UNICEF
Manjunath Kini	ILO
Divya Verma	ILO (Day 2)

State AIDS Control Societies

Nidhi Rawat	Delhi SACS

Bi-lateral Development Partners

Anand Rudra	USAID
Vibhu Garg	AIDStar/JSI
Ruchi Lall	AIDStar/JSI (Day 2)

Civil Society

Arupa Shukla	Avert Society Mumbai (also TSU to MSACS)
Mr. Shivakumar	Swasti/ Catalyst, Bangalore
Dr. Asavari	INERELA (Asia-Pacific/ India Inter-faith coalition) and Ojus Medical Institute, Mumbai
Dr. L. Ramakrishnan	Solidarity and Action Against The HIV Infection in India (SAATHII), Chennai

Proceedings: Day 1

Introduction

Mayank Agarwal (ex-JD IEC, NACO) welcomed participants and outlined the objectives of the work. He acknowledged the National Council on AIDS, which has successfully involved non-health ministries in NACO's mainstreaming effort.

Participants introduced themselves briefly. The working group identified a chair Alka Narang, co-chair Shivakumar and rapporteur L Ramakrishnan.

Presentations on NACP-III accomplishments and NACP-IV plans

Mr. Mayank Agarwal provided an overview of outputs and outcomes of NACP-III which include:

- Substantial scale-up and coverage of FSW, MSM and IDU through TIs
- 70% of long distance tuckers and 45% of high-risk migrants covered

- Counseling and Testing services scaled up and 74% of the 22 million-program target achieved.
- Nearly 15 million episodes of STI have been managed in partnership with NRHM
- IEC has been scaled up through mass-media, mid-media and interpersonal communication channels
- Nearly 5 billion condoms distributed/sold
- Ensured supply of safe blood in nearly all districts of India

He then outlined some of the recent developments and work in progress, including comprehensive migrant interventions at source, transit and destination; a scale-up of STI services; strengthening linkages between prevention and care-support-treatment; and a brief presentation on NACP-IV goals, strategies and followed, (see attachment)

Mainstreaming and Partnership accomplishments

Madhu Sharma then made a presentation on the accomplishments of NACO and its partners in mainstreaming HIV/AIDS to date. She traced its history from NACP-II, which had some noteworthy initiatives by MOHRD, Youth, Defence, Railways and Labour, to NACP-III, which saw a broader response across sectors and organizations, including the following

- Mainstreaming HIV/AIDS in schemes/ Programmes of different ministries
- Strengthening HIV/AIDS interventions in the world of Work, and the National Policy on HIV in the World of Work
- Mainstreaming HIV/AIDS in Civil Society Organizations,

- Religious organizations or Faith Based organizations
- Media.

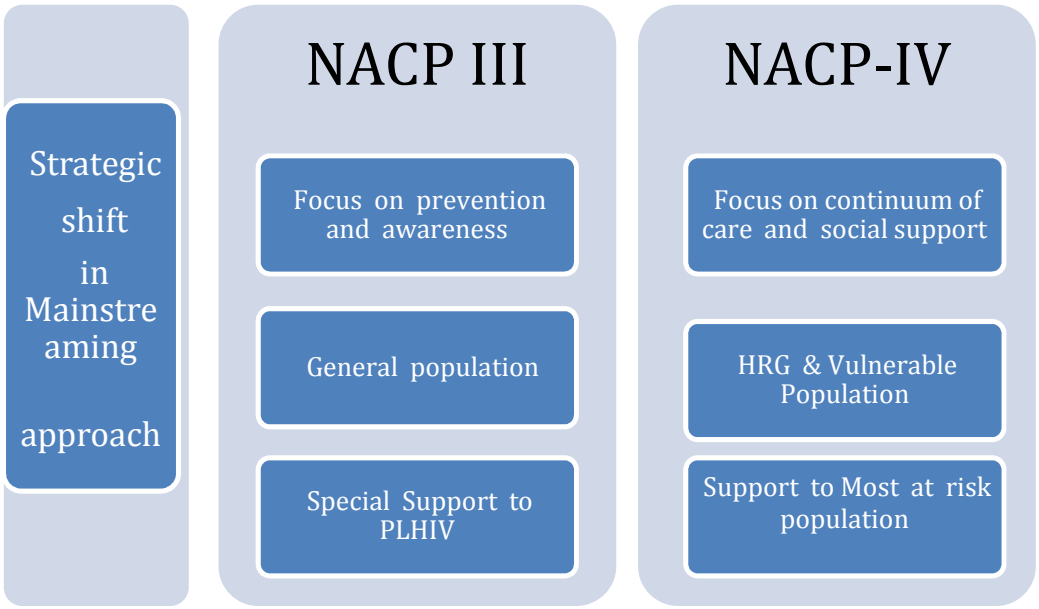
These responses included awareness creation and mainstreaming internally to a subset of the 31 ministries that are members of the National Council on AIDS, enabling environment creation in 11 of these, and pro-active inclusion of PLHIV in social support and protection schemes in six key ministries.

A list of ministries and schemes is included in the Appendix, provided by UNDP.

She emphasized the continuing need for mainstreaming and partnerships in NACP-IV in light of the following points:

- After stabilization of the infection, the need is to consolidate the prevention and treatment efforts so that nook and corners are not left out
- Prevent infection from spreading to general population by working with bridge and vulnerable sections of most-at-risk populations
- The need to support universal treatment , care and support
- Determinants of risk behavior and vulnerabilities are beyond the health sector's control
- The need to foster enabling environments: an ongoing challenge
- The reality of shrinking budgets and need for sectors beyond health to be able to take up the costs of programming.

The suggested shift in approach from NACP-III and NACP-IV is summarized in the figure below.



This schema was offered to the working group for further discussion and deliberation.

Brainstorming session on definitions

The participants then brainstormed on definitions and approaches to mainstreaming and partnerships, the relationship of these terms to concepts such as multi-sectoral response, integration, convergence, strategic partnerships, and the need for a concept that captures what is needed in the Indian context, given that it is still a concentrated epidemic.The brainstorming was facilitated by the representative from UNICEF, Ivonne Camaroni.

Some of the issues and concepts included:

- Mainstreaming is addressing HIV through policy , peoples and programs that are not primarily concerned with HIV (UNDP representative)
- Optimizing resources and work to address the issue being mainstreamed (ILO representative)
- Adopting and adapting issues (ILO representative)
- The distinction between mainstreaming that is internal to a department/ministry, contributing to internal policy and enabling environments; and external mainstreaming in their activities, was pointed out.

It was discussed that integration of systems and convergence of services referred primarily to structures and programs within the health-sector, while mainstreaming referred to structures and programs outside the health sector.

The discussion then turned to the purpose of mainstreaming, with key points being (i) need to optimize resources and (ii) need to increase access to services that go beyond health cited as the main reasons.

A participant questioned the need for mainstreaming outside of high-prevalence settings such as sub-Saharan African countries where mainstreaming is a necessity.

In response, Dr. Brijendra Singh from NACO emphasized that just as NACO depends on the health system to reach out to PLHIV, it depends on other departments for providing services not provided by health, given the limited resources and need to reach out to PLHIV and key populations.

Action Point: Participants felt that evidence-based advocacy was urgently needed to help sectors other than health to understand gains of mainstreaming from their own agenda and perspective.

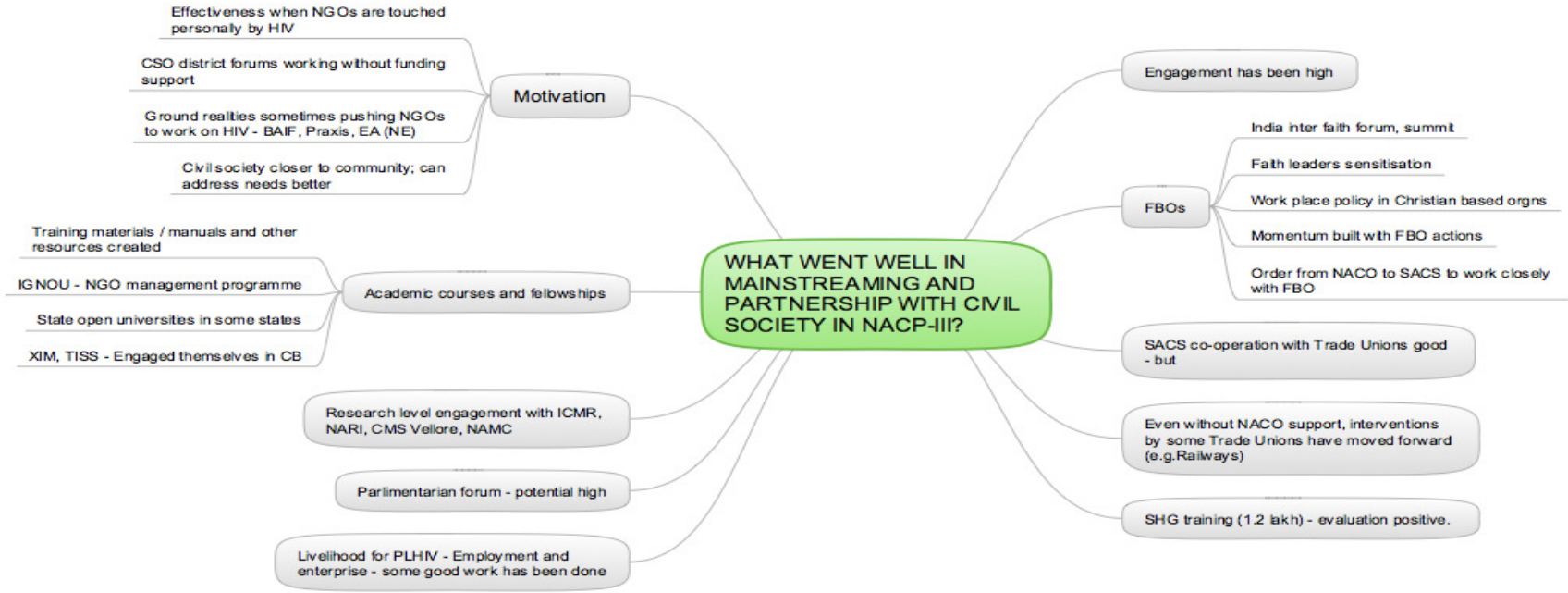
This topic was further fleshed out in the Day 2 discussion, supplemented by standard definitions from other national and international development initiatives.

Stock-taking of NACP-III efforts

The working group reviewed NACP-III mainstreaming initiatives in civil society, government and corporate sectors, identified areas of success and challenges in each.

These are summarized in the sections below:

Civil society

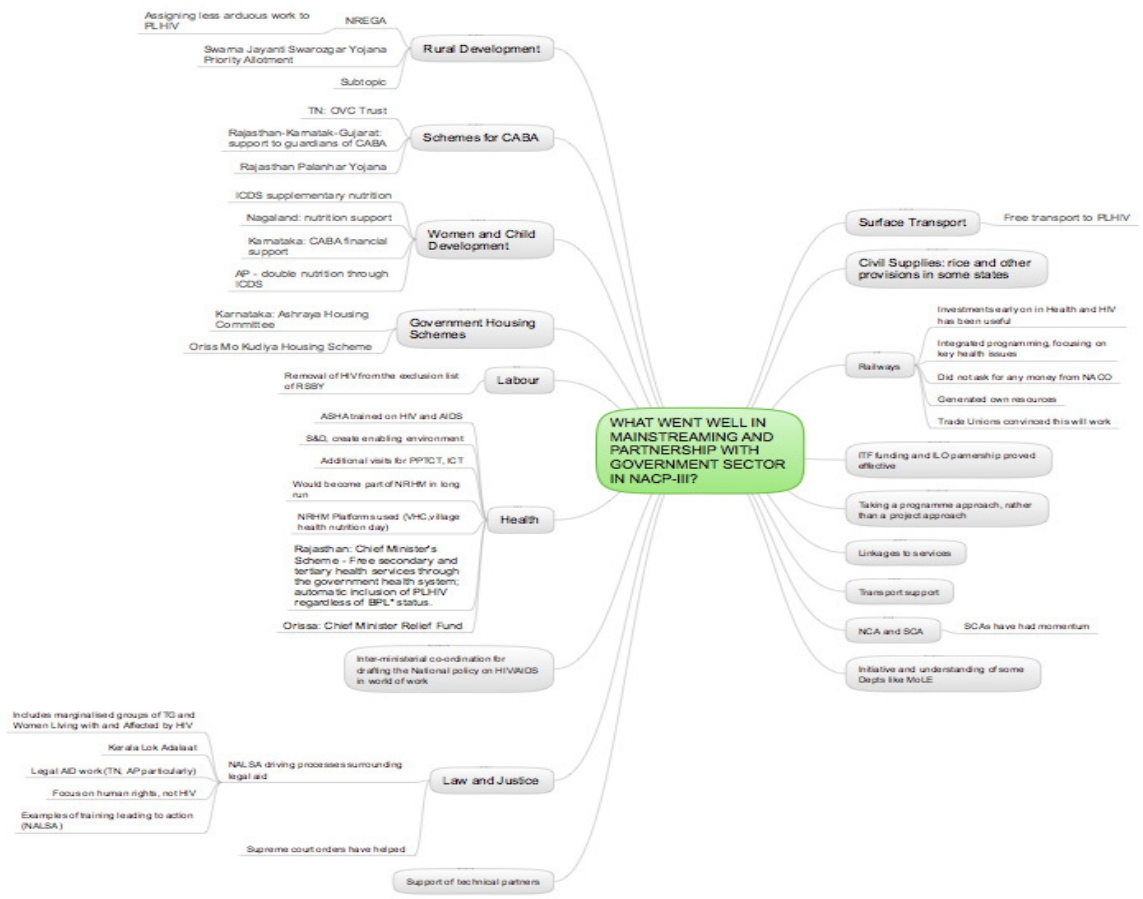


Some of the areas that did not go well with mainstreaming within the civil society sector included:

i. The tendency to view civil society as contractors rather than as partners
ii. Issues of duplication
iii. Ineffective approaches based on untested rather than previously established and validated practices
iv. Lack of clear guidelines and strategy for working with groups such as faith-based organizations and trade unions.

Action point: Government needs to engage with civil society as equal partners in conceptualization and strategy, not just as service delivery contractors

Government


WHAT WENT WELL IN MAINSTREAMING AND PARTNERSHIP WITH GOVERNMENT SECTOR IN NACP-III?
Rural Development
Assigning less arduous work to PLHIV
NREGA
Swarna Jayanti Swarozgar Yojana Priority Allotment
Subtopic
Schemes for CABA
TN: OVC Trust
Rajasthan-Karnatak-Gujarat: support to guardians of CABA
Rajasthan Palanhar Yojana
Women and Child Development
ICDS supplementary nutrition
Nagaland: nutrition support
Karnataka: CABA financial support
AP - double nutrition through ICDS
Government Housing Schemes
Karnataka: Ashraya Housing Committee
Oriss Mo Kudiya Housing Scheme
Labour
Removal of HIV from the exclusion list of RSBY
Health
ASHA trained on HIV and AIDS
S&D, create enabling environment
Additional visits for PPTCT, ICT
Would become part of NRHM in long run
NRHM Platforms used (VHC,village health nutrition day)
Rajasthan: Chief Minister's Scheme - Free secondary and tertiary health services through the government health system; automatic inclusion of PLHIV regardless of BPL* status.
Orissa: Chief Minister Relief Fund
Inter-ministerial co-ordination for drafting the National policy on HIV/AIDS in world of work
Law and Justice
Includes marginalised groups of TG and Women Living with and Affected by HIV
Kerala Lok Adalaat
Legal AID work (TN, AP particularly)
Focus on human rights, not HIV
Examples of training leading to action (NALSA)
NALSA driving processes surrounding legal aid
Supreme court orders have helped
Support of technical partners
Surface Transport
Free transport to PLHIV
Civil Supplies: rice and other provisions in some states
Railways
Investments early on in Health and HIV has been useful
Integrated programming, focusing on key health issues
Did not ask for any money from NACO
Generated own resources
Trade Unions convinced this will work
ITF funding and ILO pamenship proved effective
Taking a programme approach, rather than a project approach
Linkages to services
Transport support
NCA and SCA
SCAs have had momentum
Initiative and understanding of some Depts like MoLE

The successes are itemized in the appendix.

Some of the areas that did need improvement in mainstreaming with non-health ministries and department of governments include

i. The National Council on AIDS only met once. Clearly more engagement and action is need.
ii. Issues of coordination and clear guidelines existed.
iii. Mainstreaming was not seen as process with expected outcomes in terms of HIV/AIDS services. This resulted in gaps in follow-through from mainstreaming to actual implementation.
iv. There was not enough ownership within departments, with a significant exception being the Railways.

Action points: (a) A group of secretaries on HIV/AIDS mainstreaming, independent of the NCA, may be constituted to make it more practical. A TRG on mainstreaming with officers drawn from all major mainstreaming ministries may be formed to strategize implementation (b) Success of mainstreaming be measured in terms of tangible outcomes such as no-tolerance policy for discrimination and enhanced uptake of HIV services.

Business

The biggest success in mainstreaming HIV/AIDS in the business sector was the signing of agreements around workplace policy by seven leading corporations.
At state level, there have been initiatives by corporates for mainstreaming HIV into their policies and programs. These have been more substantial for those businesses that stand to be directly affected by the epidemic, for e.g. the private transportation sector whose truckers are vulnerable to HIV.

A general challenge identified in terms of successful mainstreaming with the business sector was the tendency of businesses to view HIV/AIDS as one of their corporate social responsibility (CSR) activities that did not go beyond image-enhancement of their business. Efforts tended to be tokenistic and fragmented.

Wrap-up of Day 1

Facilitator Shivakumar observed that it was difficult to convince people working on technical areas of HIV such as prevention, care, support and treatment on the utility of mainstreaming, as it seemed to be a nebulous concept that focused more on process and outputs than on clearly measurable outcomes.

It was also observed that the role of NACO in mainstreaming needed critical analysis. Is NACO both a facilitator and an implementer of mainstreaming? If a

facilitator, what degree of autonomy is available to implementers from other sectors and ministries?

Madhu Sharma from NACO sought input on how to respond to interest expressed by the Ministry of Agriculture in getting involved in HIV mainstreaming. The group suggested that NACO play a facilitatory and technical assistance role, prioritizing requests such as these based on their relevance and potential contribution to the national program.

Action Points: (a) Better communication is needed about the need for mainstreaming, and outcomes must be presented in reference to the objectives of the National AIDS Control Programme
(b) Follow-up and follow-through are needed, linking the activities to the results

Proceedings: Day 2

Facilitated by Shivakumar and Alka Narang, the discussions focused on comparative advantage, roles, strategies and results for civil society, corporates and government. They are summarized below.

HIV Mainstreaming within civil society

Here, civil society was defined to include NGOs (trust, society), CBOs – MARPs, PLHIV others, FBOs and Religious Leaders, Professional Associations, Trade Unions, Political forums, Private not-for-profit foundations, Cooperatives, and other CSO platforms including federations

CIVIL SOCIETY			
Comparative advantage	**Roles**	**Strategies**	**Results**
Closer to communities Cohesiveness of purpose Adaptability and flexibility Space for innovation Trust and acceptance of community (in some cases) Mass reach, particularly FBOs, Trade Unions, media Expertise Structures in place, particularly FBOs Commitment to cause Leadership, leader driven Ownership and stake, providing	Watch dog/monitoring Change in mindset (mass and micro-level), catalytic Stigma reduction Community mobilization Advocacy Source of information/feedback/dissemination Demand generation Providing services Linking to services Capacity building Non-formal mechanisms for justice Potential for direct action Knowledge management, evidence gathering Resources	Engagement mechanism/ approach Partners not contractors capacity building of NACO Bring resource pool Policy and guidelines to work with partners Resource pooling and risk pooling (Dr Brijendra) Capacity building of CBOs Mechanism to interact with all components of CSO.	National network of CSOs like water consortium Inclusive and sensitive HIV programming Following quality standard and accreditation where funding from Govt Self regulatory framework set up and followed Information sharing with NACP on uptake of services Community-led audit of NACP annually with modifications based on it. Knowledge and evidence built (capacity built, tools, approaches like roving reporter)

voice By the community Roles			Govt held responsible through watch dog function

HIV Mainstreaming within Corporate Sector

The scope of the corporate sector included Private and Public Sector agencies governed by Companies Act, Business houses, Private hospitals, institutions, pharma, Industry/sectoral associations and chambers of commerce

Corporate Sector			
Comparative advantage	**Roles**	**Strategies**	**Results**
Pool of employees Resources Efficient management structure Ability to scale-up Communication and marketing Result oriented Timely Systems Social commitment in some cases Linked to employees Existing health and safety infrastructure Geographical presence Entry point to unorganized workforce Traditional philanthropy (wide variation in commitment) Open to innovation, research, evolved risk taking	Resource providers Management Service delivery (internal and external) Sensitization of capacity building within Facilitating linkages to services Interface Materials Role models/setting standards Infrastructure and platforms New employment, protecting jobs Financial inclusion and insurance	Facilitation and implementation of work place policies Innovative financial options Sponsorship/adoption Workplace advocacy Incentivize corporate engagement and celebrate successes Cluster approach (e.g. MSME) Linking with existing social entitlements and realization of rights	Enabling social and legal environment Increased access and uptake of quality services Includes and sensitive HIV programming other entities Specific nodal person/team Owned action plan for each entity with allocation of resources Annual reports of entities with respect to HIV. Information sharing Resource allocation for CABA and women livelihood Building on existing models

Ability to addressing Stigma and Discrimination Livelihood opportunities and options Supply chain Ability to scale-up Track record of success in some cases such as sponsorship of children			

HIV Mainstreaming within the Government Sector

For mainstreaming purposes, the Government sector is defined to consist of

- Central, State, District, Block
- Ministries and Department
  - Armed forces
  - Police and paramilitary
  - Railway protection force
- Autonomous bodies
- Judiciary
- Parliament/legislature
- Statutory authorities/regulatory bodies
- Central and State publicly owned universities, labs and special bodies (ICMR, CSIR, DRDO)

Government			
Comparative advantage	**Roles**	**Strategies**	**Results**
Resources and long-term sustainability, which is stable Reach Policy making and regulatory mandate Organized and well-defined structure Clarity of responsibility,	Governance Design policy and programs Lead implementation Ensure outcomes • M&E • Quality assurance • Service delivery Regulatory • Making laws • Modifying laws • International treaties • International travel restrictions	Setting normative standards and policies, broad framework for action Decentralization Provide replicable packages (e.g. work place policy, Service delivery protocols (e.g. treatment, C&T, biomedical waste) Analysis of contribution of each Ministry to NACP	Enabling social and legal environment Increased access and uptake of quality services Includes and sensitive HIV programming other entities Nodal person/team within ministries/department, wherever not there (with capacity, ToR) Workplace policy

boundaries Infrastructure Trained human resources Influence over communities through enforcement Facilitate service delivery and enabling environment Role of last provider, Inclusion	Provide resources • Human resources • Infrastructure • Finances Build partnerships • Support PPPP • Joint schemes and programs Governance and coordination Facilitate, complement, supplement - gap fillings Social, economic and legal protection of PLHIV and MARPs Safeguard rights Research and knowledge building, knowledge sharing Capacity building	Principles • Incentivize implementation • Promote inclusiveness • Rights-based approaches Social protection programs for rehabilitation and support to the very marginalized (HIV sensitive and HIV specific) Create active functional groups and platform which are active - for coordination, sharing (need to meet regularly at least once a year)	implementation in key ministries and entities Owned action plan for each entity with allocation of resources Annual reports of entities with respect to HIV. Advocacy on Results for Development Passing HIV/AIDS Bill

Action Points: For all sectors, flesh out the strategies and expected results of mainstreaming with wider consultation in forthcoming meetings

Roles of NACO

The discussion next focused on the potential role that NACO could play with respect to mainstreaming in the three sectors. Key points are listed below.

	Government	Corporate	Civil Society
Facilitation	Forming platforms and forums, sectoral analysis, linkages, provision of test kits, resource optimization,	Mechanisms and ToRs for partnerships with PSUs and other entities	Partnerships
Coordination	Inter-ministerial, sectoral, meetings		
Technical Support (sensitization, capacity building)	Sensitization Capacity building Accreditation of laboratories Development of materials	Sensitization Capacity building (demand-driven)	Sensitization Capacity building (demand-driven)
Funding			
Normative/Policy directions	Quality standards Guidelines and Protocols, regular reviews of policies		
Monitoring and Evaluation	Joint reviews		
Knowledge Management	Creation, validation, dissemination, Analysis of epidemiological and program evidence.		
Advocacy	HIV/AIDS Bill, evidence-based advocacy, engagement with other ministries on conflicting laws, policies and social protection;	Convince corporates to be partners	

Besides these, other potential roles that were discussed included:
- Grievance redressal: ombudsman role
- Promoting innovative approaches

• Acknowledging and celebrating success, and identifying change agents and champions

Towards consensus on mainstreaming definition

The definitions that had been collected over the past two days were shared, and it was decided that these would be reviewed further. Some definitions are listed below:

1. …integrated, inclusive and multi-sectoral approach [that] transfers the ownership of HIV/AIDS issues – including its direct and indirect causes, impact and response to various stakeholders, including the government, the corporate sector and civil society organizations.

Source: NACO 2011. Mainstreaming and Partnerships page accessed at http://www.nacoonline.org/Mainstreaming_and_Partnerships, accessed May 5, 2011

2. [P]rocess of analyzing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage. The specific organizational response may include:

- putting in place policies and practice that protect staff from vulnerability to infection and support staff who are living with HIV/AIDS and its impacts, whilst also ensuring that training and recruitment takes into consideration future staff depletion rates, and future planning takes into consideration the disruption caused by increased morbidity and mortality.
- refocusing the work of the organization to ensure those infected and affected by the pandemic are included and able to benefit from their activities
- ensuring that the sector activities do not increase the vulnerability of the communities with whom they work to HIV/STIs, or undermine their options for coping with the affects of the pandemic.

Source: World Bank 2003. HIV/AIDS Mainstreaming: A Definition, Some Experiences and Strategies. Accessed at http://gametlibrary.worldbank.org/FILES/454_HIV%20mainstreaming%20experiences.pdf on May 5, 2011.

3. Mainstreaming HIV/AIDS means all sectors and organizations determining:
1 How the spread of HIV is caused or contributed to by their sector, or their operations
2 How the epidemic is likely to affect their goals, objectives and programmes
3 Where their sector/organization has a comparative advantage to respond – to limit the spread of HIV and to mitigate the impact of the epidemic
4 AND THEN TAKING ACTION!

Source: World Vision date unknown. Toolkit for Mainstreaming HIV/AIDS. Accessed at http://www.ippf.org/NR/rdonlyres/7B0867A2-58D8-4F77-864F-6D3142B9AEC1/0/Mainstreaming.pdf, accessed May 5, 2011)

Discussion Points: (a) One of the recommendations was to ensure a multi-sectoral response and addressing the needs of key populations regardless of whether the strategy were to be called mainstreaming or strategic partnerships. Perhaps, Mainstreaming is more appropriate for government sector, while it is strategic partnership with the other two sectors.
(b) Future discussions should take into consideration thematic overlaps with other working groups. Common participants can keep each other in the loop.
(c) Working group participation needs to include more government, corporate and civil society representatives.

Appendix: Mainstreaming Outputs and Outcomes from NACP-III

Social Protection Schemes for PLHIV

Category	Schemes	HIV-specific	HIV-sensitive	Features	Agency	Uptake during 2010
Health	Rashtriya Swasthya Bima Yojana		X	Removal of HIV from exclusion list for coverage	Ministry of Labour	
	PSI Star Health Insurance Scheme	X			Private sector	7,301
	Mukhya Mantri Jeevan Raksha Kosh (MMJRK)		X	Free secondary and tertiary health services through the government health system; automatic inclusion of PLHIV regardless of BPL* status.	Government of Rajasthan	
	Other insurance schemes		X		State governments	316
Transportation	Free road transportation to PLHIV for ART	X			Ministry of Surface Transport + States + Private sector	69,398
Nutrition	Integrated Child Development Scheme		X	Supplementary nutrition, health check-up, immunization, referral services, & non formal preschool education to children up to the age of six as well as nutrition of adolescent girls and pregnant and nursing women; extra nutritional support to CLHIV.	Ministry of Women and Child Development	7,771

	Antyodaya Anna Yojana		**X**	Subsidized rice or wheat provision. Automatic inclusion of PLHIV as BPL in some states.	Ministry of Civil Supplies + States	1542
	Nutritional Support	**X**		Nutrition support consists of Rice: 35-40 Kg, Dal: 15 Kg, Ghee: 5-10Kg, which is given twice a year and Paustic (a nutritional pack): 6 packets a month.	Directorate of Women Development, Government of Nagaland (State)	
	Other nutritional support schemes		**X**		State governments	6,131
Social Security	Madhu Babu Pension Yojana and		**X**	Waiving of age limit for inclusion of PLHIV	Government of Orissa	1313
	Other old age pensions		**X**	Waiving of age limit for inclusion of PLHIV	Ministry of Social Justice & Empowerment + States	23,053
	Widow and destitute pension		**X**	Waiving of age limit for inclusion of PLHIV widows		
	Orphanage		**X**		Ministry of Women and Child Development	1,489
	Ashraya Scheme		**X**		Government of Gujarat	23
	Below Poverty Line (BPL) Card		**X**		Ministry of Rural Development + States	6,658
	Short stay homes		**X**		Ministry of Women and Child Development	31
	Tabibi Sahay		**X**	Cash transfer to person suffering from TB, leprosy, cancer, PLHIV on ART	Government of Gujarat	3,800
	Dayanand Social Security Scheme for PLHA	**X**		Financial Assistance	Government of Goa	

	Chief Minister's Relief Fund		**X**	Financial assistance to needy and indigent persons for treatment from major ailments, major natural calamities. HIV included in ailments.	Government of Orissa	
	Orphans and Vulnerable Children Trust			Rs.3,000-5,000 per year orphans and vulnerable children (CLHIV)	Government of Tamil Nadu	1,496
	Sahara Card	**X**		ID Cards for PLHIV taking ART for accessing for travel concessions, priority in housing schemes, pensions, etc.	Andhra Pradesh AIDS Control Society	50,000
	Apathbandhu Scheme		**X**	Support to BPL families of accidental deaths; Inclusion of AIDS deaths. Rs. 10,000 as immediate support and 40,000 later as livelihood support.	Disaster Management along with Revenue Department, Government of Andhra Pradesh	
	Maha Maya Arthic		**X**	Rs.40/- per month to persons BPL; priority given to PLHIV families.	Government of Uttar Pradesh	
	CABA Financial Support	**X**		Rs. 800 for education, transport, Care & treatment support to the CLHIV	Dept of Women Development and Child Welfare, Government of Karnataka	
Livelihood	National Rural Employment Guarantee Scheme		**X**	Assigning less arduous work	Ministry of Rural Development	1,173
	Swarna Jayanti Swarozgar Yojana		**X**	Priority allotment	Ministry of Rural Development	100
	Livelihood schemes		**X**		NGO-led programmes, Gujarat State	162
	Other income generating schemes		**X**		Government of Gujarat	73

Housing	Indira Awas Yojana		**X**	Priority allotment	Ministry of Rural Development	100
	Mo Kudiya Housing scheme		**X**	Priority allotment	Government of Orissa	74
	Ashraya Housing Committee		**X**	Rajiv Gandhi rural and urban housing scheme: Rs.45,000 for housing for economically and socially weaker sections. PLHIV have been included within these schemes.	Under Rajiv Gandhi Rural Housing Corporation Ltd., Government of Karnataka	
Legal aid	Legal aid clinics	**X**			Ministry of Law & Justice + States	1,319
Education	Palanhar Yojana for CABA		**X**	`Rs. 500 (below age 5) or ` 675 per month per child	Government of Rajasthan, Karnataka	
	Palak Mata Pita Scheme	**X**		Rs. 1,000 (2,000 in Rajasthan) per month to guardians of AIDS orphans/ destitute children	Government of Rajasthan, Karnataka, Gujarat	35
	Children's Education Schemes	**X**			Government of Gujarat	1,156
Grievance	Grievance Redressal	**X**			National AIDS Control Organization	66