National AIDS Control programme NACP III

Social Assessment Report

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National AIDS Control Organisation

Department of AIDS Control

Ministry of Health & Family Welfare

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Abbreviations

AEP	Adolescence Education Programme
AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxillary Nurse and Midwifery
ART	Anti Retroviral Therapy
ASHA	Accreditated Social Health Activist
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organization
CCC	Community Care Centres
CDC	Centre for Disease Control
CHC	Community Health Centre
CLHIV	Children Living with HIV
CST	Care, Support and Treatment
DIC	Drop-in-Centres
FOGSY	Federation of Obstetrics and Gynaecologists
FBO	Faith Based Organisations
FSW	Female Sex workers
GFATM	Global Fund for AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HIV	Human Immuno- deficiency Virus
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IAY	Indira AwasYojana
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
ICMR	Indian Council for Medical Research
IDUs	Injecting Drug Users
IEC	Information Education Communication
ILO	International Labour Organisation
ITDA	Integrated Tribal Development Authority
MARPs	Most –at –risk –population
MW&CD	Ministry of Women and Child Development
MoHFW	Ministry of Health and Family Welfare
MSJE	Ministry of Social Justice and Empowerment
MSM	Men having sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCA	National Council on AIDS
NGO	Non-Governmental Organisation

NRHM	National Rural Health Mission
NREGS	National Rural Employment Generation Scheme
NSS	National Social Service
NYK	Nehru Yuvak Kendras
PHC	Primary Health Centre
PLHA	People living with HIV/AIDS
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
RNTCP	Revised National TB control Program
RRE	Red Ribbon Express
RTI	Reproductive Tract Infections
SACS	State AIDS Control Society
S&D	Stigma and Discrimination
SHG	Self Help Groups
SIMS	Strategic Information and Management Systems
SIMU	Strategic Information Management Unit
STI	Sexually Transmitted Infections
TAP	Tribal Action Plan
TCRTI	Tribal Cultural Research and Training Institute
TG	Transgendered Persons
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
TWG	Technical Working Group
UNAIDS	United Nations Program on HVI/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USAID	United States Agency For International Development
WLHIV	Women Living with HIV

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Executive Summary

1. Overview

National AIDS Control Organisation (NACO), since it was set up in 1992, is working to halt and reverse the spread of HIV/AIDS infection in the country. The apex body, through the National AIDS Control Programme or NACP, sets out objectives and guiding principles for a phased programmatic intervention.

Each successive phased programme, while focussing on checking the spread of disease, expanded its horizons to include behaviour change, increased decentralization by setting up State AIDS Control Societies (SACS), NGO involvement, adopting national blood policy and ART treatment for both Adults and Paediatrics.

1.1 NACP I- NACP III

The NACP-1 (1992-1999), launched in 1992, and later extended from 1997 to 1999, was the first strategic plan for prevention and control of AIDS in the country. It was an effort to develop a national public health programme in HIV/AIDS prevention and control.

Second phase of the programme (NACP-II) operated from 1999 to 2007. NACP-II aimed to reduce the spread of HIV infection in India through behaviour change and at the same time increase the ability to respond to the infection. NACP-II, moved away from a programme generating mass awareness on HIV prevention to a programme based on targeted intervention approach.

In its third phase NACP-III (2007-2012), seeks to halt and reverse the epidemic by providing an integrated package of services for prevention, care support and treatment. The key thrust areas comprised of:

- Prevention of new infections in high risk groups and general population through:
    - Saturation of coverage of high risk groups with targeted interventions (TIs), and
    - Scaled up interventions in the general population
- Providing greater care, support and treatment to a larger number of people living with HIV/AIDS.
- Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels.
- Strengthening a Nation-wide Strategic Information Management System.

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Objective of Social Assessment of NACP III

To assess the equity, gender and social inclusion aspect of NACPIII, so as to strengthen the existing programs and to take corrective measures in NACP-IV

2. Methodology

The social assessment is based primarily on review of the publications, of the activities undertaken by various stakeholders during the period 2007-2012. To understand the perspectives of the key stakeholders, field based interactions with them were conducted. The methodology can be broadly divided into:

- Desk Review
- Field based interactions with the States AIDS Control Society.

3. Social Assessment of NACP-III

NACP- III maintained a thrust on creating an enabling environment so that there is a greater acceptance of infected and affected people by the community. Enabling environment has a ripple effect on prevention, care and support of HIV, and most importantly, when the human rights i.e. to live a life of dignity, without stigma and discrimination are respected, it helps society in many ways.

To reduce stigma and discrimination associated with the infected and affected persons and ensure that they have an access to prevention and quality treatment, care, insurance and legal services, NACP – III took affirmative actions, both for infected and affected population. The actions were directed towards:

1. Creating an Enabling Environment
2. Addressing Stigma and Discrimination
3. Addressing Human Rights, Legal and Ethical Issues in health settings
4. Addressing the Gender Equality
5. Addressing the needs of the Vulnerable and Specific Groups

4. Lessons Learnt

The programme, in course of its implementation, adopted many innovative strategies to meet its objective "to halt the spread and reverse the epidemic".

4.1 Innovations

NACP- III is acclaimed globally as a participative programme, and it is to the credit of the policy makers that to halt and reverse the epidemic, that they, along with strengthening the existing structures, also adopted innovative strategies and reached out to the unreached. Some of the innovative strategies include - (i) Separate TG interventions; (ii) Link Worker Schemes; and (iii) Innovations in communication strategies

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4.2 Best Practices

In course of its implementation NACP-III has come up with models of best practices under various strategies due to the magnitude of their reach, originality and in fighting stigma and discrimination, thereby safe guarding the rights of the infected and affected.

5. Social Assessments of HIV / AIDS in Tribal Areas

The social assessment also included Tribal Action Plans (TAPs) prepared so far by the states where a significant tribal population exists.

Tribal Action Plan

Based on a comprehensive understanding gained from stakeholder consultations and a social assessment for NACP III, the National AIDS Control Organisation designed Tribal Action Plan (TAP) to improve the access of tribal people to information, prevention and comprehensive care and support.

6. Key Issues and Challenges

NACO has successfully implemented NACP- III and to a very large extent has come very close to its objective of halting and reversing the epidemic. According to recent estimates, the HIV prevalence overall in the country has come down, but new pockets have also emerged posing new issues and challenges.[1] The challenges mainly emerged in the following areas:

- Coverage of hard to reach and mobile most at risk population
- Care and Support
- Stigma and Discrimination in certain areas of services
- Enabling Environment

7. Recommendations

Strategies have been developed to overcome the challenges have been grouped under:

- Scaling up and monitoring quality of Coverage
- Strengthening Enabling Environment
- Enhancing access to services for Care, Support and Treatment
- Strengthening the services under STI Management
- Increased awareness and widespread communication strategies
- Bringing focus on Mainstreaming activities
- Capacity building initiatives

[1]Annual Report NACO 2010-2011

Chapter 1: Overview

National AIDS Control Organisation (NACO), since its inception in 1992, has been working to halt and reverse the spread of HIV/AIDS infection in the country. The apex body, through the National AIDS Control Programme or NACP, sets out objectives and guiding principles for a phased programmatic intervention.

Each successive phased programme, while focussing on checking the spread of infection, has expanded its horizons to include behaviour change, increased decentralization by setting up State AIDS Control Societies (SACS), NGO involvement, adopting national blood policy and ART treatment for both Adults and Paediatrics.

1.1 National AIDS Control Programme: I, II and III

The NACP-1 (1992-1999), launched in 1992, later extended from 1997 to 1999, was the first strategic plan for prevention and control of AIDS in the country. It was an effort to develop a national public health programme in HIV/AIDS prevention and control. The programme aimed (i) to prevent HIV transmission; (ii) to decrease the morbidity and mortality associated with HIV infection; and (iii) to minimise the socio-economic impact of HIV infection.

To achieve its objectives, this phase provided services such as education campaigns, protection of the blood supply, condom promotion, and a system to monitor the prevalence of HIV, treatment for sexually transmitted diseases and limited treatment for AIDS-related conditions. To this, later components of targeted intervention and inter-sector collaborations were added.

The second phase of the programme (NACP-II) operated from 1999 to 2007. NACP-II aimed to reduce the spread of HIV infection in India through behaviour change and at the same time increase the ability to respond to the infection. NACP-II, moved away from a programme generating mass awareness on HIV prevention to a programme based on targeted intervention approach.

The nature of HIV epidemic in the country necessitated a change in approach. The targeted intervention approach intended at checking the spread of disease from high risk behaviour population to general population through behaviour change. The High Risk Group (HRG) includes female sex workers, men having sex with men, injecting drug users, street children, prisoners, truck drivers and migrant labour. The interventions through non-governmental organisations (NGOs) were targeted at these groups.

To bring about a change in behaviour, the NGO's involved peer educators to counsel,provide condoms through social marketing and provide information to encourage a change in behaviour ("behaviour change communication" (BCC)). Alongside, NACP-II continued with its programme for generating mass awareness among general population.

In its third phase NACP-III (2007-2012), seeks to halt and reverse the epidemic by providing an integrated package of (a) preventing new infections in high risk groups and general population through: (i)Saturation of coverage of high risk groups with targeted interventions

(TIs); and (ii) Scaled up interventions in the general population; (b) Providing greater care, support and treatment to larger number of PLHA; (c) Strengthening the infrastructure, systems and human resources for scaling-up prevention, care, support and treatment programme sat the district, state and national level; and (d) strengthening the nationwide Strategic Information Management System.

In its third phase NACP-III (2007-2012), seeks to halt and reverse the epidemic by providing an integrated package of services for prevention, care support and treatment. The key thrust areas comprised of

- Prevention of new infections in high risk groups and general population through:
    - Saturation of coverage of high risk groups with targeted interventions (TIs), and
    - Scaled up interventions in the general population
- Providing greater care, support and treatment to a larger number of people living with HIV/AIDS.
- Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels.
- Strengthening a nation-wide Strategic Information Management System.

Mainstreaming and partnerships was recognized as a key approach in NACPIII to facilitate multi-sectoral response engaging a wide range of stakeholders. It was visualized as an opportunity to scale up the dissemination of HIV prevention messages by mainstreaming the min government offices, public and private sector and civil society organizations.

NACP-III initiated the process to mainstream HIV/AIDS into various government ministries, which was part of larger NACP but not part of World Bank supported activity. These would be continued especially with activities under National Rural Health Mission (NRHM) and be further strengthened under NACP-IV over and above the World Bank supported efforts under NACSP.

The gender and social inclusion has been a cutting across perspective for the planning of NACP IV, which is evident from the exhaustive consultative process undertaken in the planning stage. NACO initiated the process of NACP-IV, engaging in wide range of consultations with large number of stakeholders or partners[2]. The stakeholders or partners include government departments, development partners, non-governmental organizations, civil society, representatives of people living with HIV, positive networks and experts in various subjects. Stakeholders' representatives formed 15 working groups and over 20 sub groups to give specific inputs for NACP-IV. The working groups formed gave inputs on (i) Program Implementation and Organizational Restructuring; (ii) Finance management; (iii) procurement;(iv)Lab services; (v)STI/RTI; (vi) Condom Programming; (vii) Communication Advocacy and community mobilisation;(viii) GIPA stigma and ethical issues; (ix)

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mainstreaming and partnerships;(x) blood safety;(xi)ICTC/PPTC;(xii) Care, Support and Treatment (CST);(xiii) Strategic Information Management System (SIMS); (xiv) Gender, Youth and adolescence; and (xv) Targeted interventions.In addition to the above working groups , inputs from various other stakeholders and partners were taken through workshops and e-consultations for preparation of NACP IV.

While NACP IV would guide the implementation of all the components of NACP, the world bank supported would be provided through NACSP mainly for prevention efforts.

1.2 Need for the Social Assessment

To strengthen the existing programs and to take corrective measures if required it is important to understand and learn the lessons that have emerged from the implementation of NACP-III especially, with regard to:

- How issues relating to social inclusion and gender equality were addressed
- How NACP-III addressed needs and vulnerabilities of specific groups such as youth, migrants, children, poor, women and children, sexual minorities, positive people, HRGs.
- What is the situation of the Tribal people with regard to vulnerabilities and risks (including HIV/AIDS prevalence, changing trends, sexual practices and behaviours, access to IEC/BCC,access to services)

Lessons learnt will help NACO to develop adequate strategies and activities to address the gaps and address the issues in more efficient manner.

1.3 Structure of the document

The social assessment document is divided into four sections.

Section I: Discusses in brief the methodology adopted and reviews the efforts made at social inclusion and gender equality NACP-III and Lessons Learnt during the course of implementing NACP –III with regard to innovations and best practices.

Section-II : Efforts made at reaching out to the marginalised including tribal's through NACP. The nature of the epidemic among the tribal population and issues of care, support and treatment and stigma and Discrimination therein.

Section III The last section of this document, discusses about key issues and challenges emerging out of NACP-III and the way forward .

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Chapter 2: Methodology

The social assessment is based primarily on review of publications, of activities undertaken by various stakeholders during the period 2007-2012. To understand the perspectives of the stakeholders, field based interactions with them were conducted. The methodology can be broadly divided into:

- Desk Review
- Field based interactions with the personnel of States AIDS Control Society.

2.1 Desk Review

For desk review, publications on HIV/AIDS available in public domain on NACO, SACS and other websites were read and analysed. The publications are available as:

I. **Policy Document**: It draws the roadmap for the entire programme period.

II. **Annual Reports:** It gives stakeholders and other interested people information about the department's activities and financial performance in the preceding financial year.

III. **Operational Guidelines:** Operational Guidelines provide a roadmap to facilitate the implementation of various strategies of NACP- III. While all the operational guidelines touched upon the issues of social concern, however, in the below mentioned documents the issues of social relevance feature prominently.

a. **Targeted Interventions for Truckers:** Review of this document helped in understanding the type of strategies planned: How, when and who will be responsible for the implementation; definition/ terminology of "Trucker" for the purpose of HIV/AIDS programming.

b. **Targeted Interventions for HRGs**: The guideline describes the operational details of TI projects with FSW, MSM and IDUs. The guidelines also provide detailed information on issues related to programme management, services required in terms of human resources, infrastructure; linkages and monitoring and evaluation indicators for each programme area.

c. **Targeted Interventions for Migrants:** The guidelines helps in understanding the type of strategies planned: how, when and who will be responsible for the implementation; definition/ terminology of "migrant" for the purpose of HIV/AIDS programming.

d. **Antiretroviral Therapy Guidelines for HIV infected adults and adolescence including post exposure:** These guidelines are intended to assist physicians prescribing ART, as well as the staff in the ART centres, with the practical issues regarding the treatment of HIV/AIDS. It is critical document for care, support and treatment. They contain recommendations to be used in the framework of the national

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programme as well as in dealing with special cases, in view of the role of the private sector in the provision of ART**.**

e. **Guidelines for HIV care and Treatment in Infants:** The main thrust areas of this document include the newborn component of PPTCT; follow up of the HIV-exposed infant, counselling mothers to decide the right infant feeding choices, PCP prophylaxis and appropriate diagnosis of infected children.

f. **Link Worker Scheme Operational Guidelines:** The guidelines provide useful insight to the implementers on how to go about the scheme. Clearly puts down the role of the Link Worker, under the scheme. Emphasis in the guide lines is on, building skills of human resource by enhancing the mode of training. It takes care of the state –specific variations.

g. **Operational Guidelines for Program Managers and Service Providers for strengthening STI/RTI:** The operational guidelines have been developed which explains 'what' has to be done by 'whom' and 'how' and 'who' will monitor and how to document. These guidelines define the minimum standards for STI/RTI services for STI/RTI clinics.

IV **Training Modules:** Technical training manuals on various aspects of the programme are available to build the capacity of the human resource for managing the programme.

V. **Research Studies:** To assess the HIV prevalence and other HIV related issues in the country; whole lot of research is undertaken from time to time.

VI. **Monographs:** Monographs on various themes are available.

VII. **Newsletters:** The periodic newsletters, provides update on activities around the country.

2.2 Analysis of Publications

Analysis of various publications highlight following issues of social relevance include:

1. Risk and Vulnerabilities of High Risk Groups and Bridge Population
2. Stigma and Discrimination faced by People Living/Affected with HIV
3. Access to Care , Support and Treatment
4. Mainstreaming with other relevant government departments
5. Strengthening Capacity for a consolidated response

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The research studies conducted in above areas cover one or more aspects of HIV and are noteworthy in understanding the social relevance.

2.3 Works of Social Relevance: An Illustrative List

1. Gender and Impact on HIV/AIDS

This report by NCAER and UNDP clearly brings out the adverse impact of HIV and AIDS on women and female children and highlights the heavy burden of care, domestic work and economic responsibilities on women in the HIV households and the role of women as caregivers. The report focuses on the gender differences in the health-seeking behaviour and out-of-pocket expenditure incurred by the HIV households on the treatment of opportunistic infections (OIs) and the gender gaps in the education of children from the HIV affected households. In our society, where gender differences exist in all walks of life, it is not surprising that HIV-positive women face stigma and discrimination in the family and community. The study finds lack of knowledge among women about the modes of transmission of the infection to be greatly responsible for their negative attitude towards PLWHA and their families. A comparison of HIV widow households with the other HIV households in terms of their living conditions, the assets and consumer durables they possess, household income, and pattern of consumption, savings and borrowings brings out the pitiable economic condition of the widows.

2. HIV/AIDS related stigma and discrimination: A conceptual framework and Agenda for Action.

This research paper by Population Council, (i)analyzes the sources of S&D, the ways in which HIV/AIDS-related S&D manifests itself, and the contexts in which HIV/AIDS-related S&D take place. (ii) Highlights the limitations of current thinking and argues that S&D need to be understood as social rather than individual process; and (iii) identifies an agenda for research and intervention.

Talking about sources of stigma and discrimination, and states to understand the ways in which HIV/AIDS-related S&D appear and the contexts in which they occur, we first need to understand how they interact with pre-existing S&D associated with sexuality, gender, race, and poverty. HIV/AIDS-related S&D also interact with pre existing fears about contagion and disease. Early AIDS metaphors—as death, as horror, as punishment, as guilt, as shame, and solitude , have exacerbated these fears, reinforcing and legitimizing stigmatization and discrimination. It discusses of types of stigma and related discrimination.

2.4 Field Based Interactions

To understand the perspectives of the programme implementers, on the following:

- Reaching the " hard to reach" population including the tribal population areas and
- Proposed convergence of NACP activities with NRHM.

Interactions were held with the State AIDS Control Societies of Andhra Pradesh and Chhattisgarh, with field visits to DAPCU, training programmes and service delivery points at the district levels.

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Chapter 3: Social Assessment of NACP-III

A key challenge before NACP-III, was to develop an inclusive holistic program which would importantly cover the key emerging areas such as gender equality, vulnerability among specific groups, human rights, legal and ethical issues and stigma and discrimination. These issues play critical role in prevention of HIV and AIDS and to halt and reverse the epidemic.

3.1 Social Inclusion and Gender Equality

NACP- III gave thrust on creating enabling environment so that there is a greater acceptance of infected and affected people by the community. Enabling environment has a rippling effect on prevention, care and support of HIV, most importantly, when the human rights i.e. to live life of dignity, without stigma and discrimination, are respected, it helps society in many ways.

To reduce stigma and discrimination associated with the infected and affected persons and enhance their access to prevention, quality treatment, care, and support services including legal services, NACP – III took affirmative steps through following strategies., through all of these were not supported by the World Bank

- Creating Enabling Environment
- Addressing Stigma and Discrimination
- Addressing Human Rights, Legal and Ethical Issues in health settings
- Addressing the gender equality
- Addressing the needs of the vulnerable and specific groups

3.2 Creating Enabling Environment

The programme built upon the changed role of PLHIV under NACP –II from a mere beneficiary of services to becoming important partners of NACO, SACS, civil society organizations and service providers.

NACP- III sought greater involvement of people living with AIDS (GIPA). It strengthened the role of PLHIV by bring them on board of SACS and NACO as members of executive committees. The idea behind the move is to work in partnership with PLHA and other stakeholders towards creating an enabling environment by addressing issues of stigma, discrimination, legal and ethical concerns. Importantly, positioning them as advocates for prevention; as well as care, support and treatment programmes including setting up of Drop-in centres. PLHA network exists, now at sub-district, district, state and national level.

During NACP-III, People Living with HIV have been involved in various important committees and forums including the following:

- National Council on AIDS (NCA) and State Councils on AIDS (SCAs)
- Technical Resource Groups (TRGs)
- Country Coordination Mechanism (CCM)
- Grievance Redressal Committees at the state level

PLHIV are involved in training programmes, advocacy workshops and outreach activities as resource persons/ positive speakers. A number of them are working as counsellors, peer and outreach workers and health care providers under different components of the programme. As partners in the process of mainstreaming, PLHIV and their networks have facilitated leveraging various welfare schemes such as free transport to ART centres, supplementary nutrition, widow pension scheme, legal aid etc. Apart from national level networks, today there are registered networks of PLHIV in almost all states and in about 300 districts. 242 Drop-in-Centres are currently functional primarily through these networks providing psycho-social support, counselling and referral services and linkages to welfare schemes to PLHIV. Grievance Redressal Committees have been formed at the Statelevel to address issues of stigma and discrimination against PLHIV particularly in the context of health care settings.

Targeted interventions also have mechanisms to create enabling environment by carrying out advocacy with local government functionaries and key stake holders. This has not only brought changes in the mind set about the marginalised groups but has also addressed the stigma related to high risk groups in health care settings.

3.3 Addressing Stigma and Discrimination

Stigma and discrimination is an obstacle to an effective response to HIV/AIDS, as it heightens their vulnerability to HIV/AIDS by placing them in a vicious cycle of S&D.

Most often S&D from service providers - medical, non-medical, school teacher, government and private sectors is the first to be perceived though it is a cutting across social phenomenon prevailing in all social settings like family, community and workplace etc. Further, PLHIV and vulnerable populations themselves are largely unaware of their rights. There is also evidence that S&D is in many aspects a gender related phenomenon.

National AIDS Prevention and Control Policy also clearly enunciates that "discrimination against people living with HIV/AIDS, denies their rights to access health care, information and other social and economic rights guaranteed by the Constitution to its citizens."

Addressing stigma and discrimination has found a prominent place in the national agenda. NACP-III addressed the issue of stigma and discrimination at all levels through communication, research and advocacy, capacity development and partnership building.

The NACP III guiding principles laid emphasis on

creation of an enabling environment wherein those infected and affected by HIV could lead a life of dignity. The major initiatives taken during the NACP-III which addressed the issue of stigma and discrimination are as follows:

(i) Multi-media mass mobilization campaigns such as Red Ribbon Express (RRE) which involved positive networks for campaign outreach and generated a strong community dialogue on the issue.
(ii) Spots on radio and TV with messages by celebrities on the issue of stigma and discrimination; special episodes on the issue of stigma in long format radio and TV programmes such as "*Kalyani Health Magazine*" and TV serial "*Kyunki Jeena Issi Kaa Naam Hai*".
(iii) Folk media performances in rural areas with focus on stigma and discrimination.
(iv) Sensitization of medical and para-medical staffs on stigma during training programmes; inclusion of stigma and discrimination components within the sensitization programmes for grassroots workers such as SHG, AWW, ASHA, ANM and members of PRI; advocacy and sensitization programmes for parliamentarians, legislatures, faith based leaders, judiciary, police and other stakeholders; media sensitization programmes for journalists on stigma free reporting.
(v) Involvement of PLHIV as positive speakers at various national and international forums, training programmes and advocacy workshops.
(vi) Linkages established between various service centres and positive networks; setting up of Drop-in-Centres to provide platform for psycho-social support to PLHIV in the districts and to facilitate access to services.
(vii) Formation of grievance redressal committees in the states to address the issue particularly in medical settings.
(viii) Involvement of PLHIV in various mainstreaming programmes and in leveraging several Government welfare schemes to mitigate the impact of the epidemic on PLHIVs.
(ix) Systems to take prompt actions taken through concerned authorities in case of reports of stigma and discrimination.

3.4 Addressing Human Rights, Legal and Ethical Issues in Health settings

National AIDS Prevention and Control Policy (2002) aims to respect the rights of people living with HIV/AIDS and vulnerable populations. The rights of the PLHAs received further impetus by the policy which described any form of Stigma & Discrimination as "discrimination against people living with HIV/AIDS, denies their rights to access health care, information and other social and economic rights guaranteed by the Constitution to its citizens."

Several policy initiatives have been initiated during NACP-III these include:

- National policy on HIV/ AIDS and the World of Work ensuring non-discriminatory workplace policies and referrals/ linkages to services, has been

approved by the Union Cabinet and roll out led by the Ministry of Labour & Employment.
- The operational guidelines for Tribal Action Plan were finalized and rolled out in 13 States.

In addition to the above, there are several ongoing initiatives- engaging with insurance development regulatory authority to bring PLHIV within the ambit of health and life insurance products, convergence with NRHM, strengthening implementation of workplace policy and addressing the vulnerabilities of migrants.

3.5 Addressing the Gender Equality

The impact of HIV and AIDS reaches far beyond the health sector with severe economic and social consequences. Like any other epidemic, it is much more severe on women than men.

Biological, socio-cultural and economic–factors make women and young girls more vulnerable to HIV and AIDS. The HIV is more easily transmitted from men to women than from women to men; male-to-female transmission during sex is about twice as likely as female to-male transmission.

The low status of women, in our country coupled with poverty, early marriage, trafficking, sex-work, migration, lack of education and gender discrimination make them more vulnerable to HIV infection.

A study on gender by NACO, NCAER and UNDP in NACP II, established that consequence of AIDS epidemic is the increasing number of widows and that too HIV-positive widow. Further, a HIV positive widow is likely to experience tremendous financial burden as well as double stigmatisation–as a widow and as an HIV-positive individual.[3] In view of above observation, NACP III has taken number of steps to address such issues and that scenario has been changed now.

NACP- III placed reproductive rights of women and adolescent girls high on agenda and this is reflected in the following principles;

- Equitable access at all levels in the national HIV response
- Non-judgmental HIV response with a commitment to social inclusion, and
- Create an enabling environment to address the legal and socio- economic barriers which are likely to adversely impact the outcomes of national HIV response.
- Promote Behaviour change to enable men and women to be safe from HIV and men to be responsible and equal partners in prevention of HIV
- Reduce the prevalent stigma and discrimination especially in the health care settings
- NACO places a strong gender framework. The guidelines were developed on women and HIV to guide gender based response to the epidemic.

[3] Gender: Impact of HIV/ AIDS in India. Pg8

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The achievements under various components of NACP-III have addressed gender equality:
(i) Prevention:

- HIV prevalence among FSWs has reduced from about 10% in 2003 to 4.9 % in 2009 with the increase in coverage of TIs reaching 6.78 lakh FSWs out of estimated 8.68 lakh FSWs.
- The Link Workers Scheme (LWS) reaching out to high risk women in rural areas including spouses of migrants in 208 vulnerable districts.
- About 40% of the people reached through the RRE campaign were women.
- Mass media campaigns in TV and radio supported by mid-media, outdoor and IPC channels continued to focus on women issues. The thematic campaigns on ICTC/
- PPTCT, condoms, STI, stigma and discrimination, blood safety etc. addressed men and women alike.
- In 2007 NACO developed a booklet titled "*Gram Sandesh - HIV/ AIDS & the Role of Women Members of Panchayati Raj Institutions*" which was distributed at the gram panchayat level deliberating action from PRIs on issues of women's vulnerability and stigma & discrimination. Women PRIs were also reached through mainstreaming with M/o Panchayati Raj through training programmes which incorporated HIV as a component.
- A large number of women SHGs, ANMs, ASHA & AWWs have been trained on HIV/AIDS using a specially designed module- 'Shaping Our Lives' to reach out to rural women & adolescent girls with HIV prevention knowledge, information on care, support, treatment services and on stigma & discrimination issues.

(ii) Counselling & Testing, Care, Support & Treatment:

- The number of women accessing ICTC/ PPTCT and ART services is steadily increasing.
- 242 Drop in Centres (DICs) are operational in the country providing psychosocial support and linkages to services for PLHIV, including women at the district level.. About 350 Community Care Centres (CCCs) exist to provide access to necessary care & treatment support. WLHIV are referred from the CCCs to various services centres for further assistance.

(iii) Stigma, Discrimination & Social Protection:

Stigma & discrimination has been both a cause and consequence of HIV. NACP III initiated efforts at mainstreaming response involving other government ministries/ departments in addressing stigma, discrimination and social protection issues for women living with & affected by HIV. Various social security measures for WLHIV have also been ensured. Some of the key achievements are:

- Free legal aid in some states for legal suits related to property, insurance claims, etc.
- Widow pension scheme in some states providing for financial support.
- Positive Women Networks at national/ state / district levels have been encouraged to advocate and promote access and utilization of HIV related services for women.

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- Grievance redressal systems at the state levels advocate and initiate protective action against stigma & discrimination.
- Linkages of WLHIV and CLHIV to shelter homes and care homes under M/o Women and Child Development or the M/o Social Justice & Empowerment.

3.6 Addressing the Needs of the Vulnerable and Specific Groups

The third phase of the National AIDS control program sees amongst general population apart from women, youth, especially in high prevalence districts, children, including girls in special settings , school drop outs, orphans of HIV/AIDS infected/ affected as vulnerable. Acknowledging their needs as special has specific interventions.

3.6.1 Addressing Youth (i.e. 15-29 years age group)

The interventions designed are based on the youth groups being targeted. The Adolescence Education Programme (AEP) is aimed at providing correct information to youth in the age group of 15-29 years on HIV infection.

Youth groups are re-categorized into three sub-groups based on their exposure to HIV infection. (Table1)

Table 1: Categorization of youth groups based on exposure to HIV infection

Youth Groups Category	Population	Approach to educate on HIV infection
Category A **Young people in general population** ,	• In schools, • In colleges, • In universities • Uniformed services and; • Out of school/non student • youth in community	• Through curriculum • Mainstreaming efforts initiated by respective ministries. • Mid and mass media campaign
Category B **Vulnerable young people in high and low vulnerable districts**	• Districts with large concentration of FSWs, IDUs, MSM, significant out migration,	• Behaviour change education through link workers and volunteers. Health and communication campaign in high migrant source districts

Category C **Young people most at risk**	• Adolescence at Sex work • Young IDUs • Street Children • Working Children	• Peer Education approach through TIs • Ownership building at most risk population level

Under NACP-III following efforts were made for prevention of HIV/AIDS among youth.

- Adolescence Education Programme (AEP)
- Red Ribbon Clubs in colleges (RRC)
- Progammes for Out-of-School youth through
    - Link workers
    - *Nehru Yuvak Kendra Sangathan* Youth Clubs
    - National Service Scheme (NSS)
- Multi-media campaign focussing on youth in North-Eastern India.

These efforts aim at providing adolescents with age appropriate information on the process of growing up during adolescence, HIV/AIDS, STIs and substance abuse.

3.6.2 Addressing Children (i.e. Below 15 years of age)

NACP-III has put in place a policy for provisioning ART for children through the following:

- Guidelines on paediatric HIV care for each level of the health system
- Early diagnosis and treatment for HIV exposed children
- Special training to counsellors for counselling HIV positive children and their parents;
- Linkages with social sector programmes for accessing social support for infected and affected children
- Outreach and transportation subsidy to facilitate ART and follow up,
- Nutritional, educational, recreational and skill development support; and
- By establishing and enforcing minimum standards of care and protection in institutional, foster care and community-based care systems.

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Chapter 4: Lessons Learnt

The programme in course of its implementation adopted many innovative strategies to come close to its objective “to halt the spread and reverse the epidemic” and in the process some best practices were set up. Both these aspects have been looked from social inclusion view point.

4.1 Innovations

NACP- III is acclaimed globally as participative programme, it is to the credit of the policy makers that to halt and reverse the epidemic, that they alongside strengthening existing structures, felt the need to innovate and reach out to the unreached.

Separate Package of services for Transgendered and Hijra Persons (TG): One of the important innovations is recognizing the needs of TGs – hijras and have developed separate intervention packages.

Link worker Scheme: NACP-III has made efforts to reach high risk and vulnerable population in rural areas through the Link Workers Scheme. Currently these are being implemented in A &B category districts.

OST programme – Through targeted intervention projects, NACO could reach out about 80% of the IDUs who are socially and economically marginalized. Efforts have been made for significant scale up of OST progamme across the country. Initiation of OST centers in government health facilities is another commendable achievement in NACP III.

Migrant Intervention - Under targeted intervention programme, migrant intervention strategies were revised for better and effective coverage of vulnerable migrants and their family who are socially and economically marginalized.

Other innovative activities which contributed to social inclusion include:

Red Ribbon Express Project: Two phases of the project were implemented during 2007-08 and 2009-10, which directly reached out to 62 lakh and 80 lakh people respectively with messages on HIV/AIDS. The project also delivered services for HIV testing and general health check-ups. Major achievements of this project include:

- Higher knowledge levels about HIV/ AIDS among those exposed to the project.
- Bringing the political leadership on one platform cutting across party lines and mainstreaming the programme at the district and grassroots levels with non-health departments.
- Creating a large pool of trained resource persons including SHG leaders, PRI members, AWW, ANM, and ASHA as part of the on-board training programme of the project.
- Generating a healthy community dialogue particularly in rural areas on issues of sex and sexuality.

Multi-media Campaign in the Northeast: Special multi-media campaigns were implemented in eight states of the North East region to disseminate HIV/ AIDS messages through a series of music and sports events. Special effort was made to reach out-of-school youth through youth clubs at. FBOs were also involved in the intervention. The campaigns generated significant participation of youth in all the states.

Innovative Use of Radio: Examples of these include the radio programme by positive journalists for rural populations in Maharashtra, programme through cable radio in a Government hospital in Chennai, the promotion of radio listeners clubs, and several others.

4.2 Best Practices

In course of its implementation NACP-III set up some of the best practices under various strategies, these are considered best due to magnitude of its reach, originality and in fighting stigma and discrimination thereby safe guarding the rights of the infected and affected. A few illustrative best practices from social inclusion mandate are captured:

4.2.1 Communication Strategy

4.2.1(a) Red Ribbon Express

Conceptualized by the Rajiv Gandhi Foundation, the project was implemented by the National AIDS Control Organisation (NACO) in collaboration with the Ministry of Railways, Ministry of Youth Affairs, *Nehru Yuva Kendra Sangathan* (NYKS), United Nations Children's Fund (UNICEF) and other stakeholders.

The special seven-bogey train was supplemented by two exhibition buses, folk troupes and cycle caravans that were assembled to create greater impact and wider reach. Specially trained volunteers fanned out to villages and spread the messages on HIV. The local people were mobilized to come and visit the train at the nearest halt station.

The RRE with message, "One Train, One Message, uniting India against AIDS" is the world's largest mass mobilisation campaign against HIV/AIDS. The train covered 180 stations in 24 states and reach 6.2 million people.

4.2.1(b) TV Serial: *Kyunki Jina Issi ka Naam Hai* (HINDI)

An entertainment-education programme *Kyunki Jeena Issi Ka Naam Hai* was aired on *Doordarshan*, India's national channel. The programmed aired in year 2009, reached core audience of 40 million mostly rural poor women daily, in six Hindi-speaking states with key information, advice and stories that will help save lives and improve the well-being of children and women

Kyunki... addressed many of the underlying behavioural issues that are important to India's social development, especially progress in improving child survival, maternal mortality, nutrition, child protection, emergency response, HIV prevention, girls' education, access to safe drinking water and improved personal hygiene.

4.2.1(c) *Dillu Dura* Campaign: Tamil Nadu

A state level campaign initiated by Tamil Nadu Government. 12 vans consisting of 10 cultural performers in each van reached out to the villages in Madurai. The campaign van was preceded by cultural troupes, who enacted simple skits to convey the message that tying talisman or trying some locally jostled-up remedies will not cure HIV. What is often disturbing their minds is whether they have actually contracted the disease and if so how to get authenticated treatment.

The campaign motivated the most vulnerable population to access the "*Nambikkai Maiyam*" (Integrated Counselling and Testing Centre - ICTC) to seek answers to their doubts on HIV.

4.3 Best Practices in Link Workers Scheme

Maharashtra

Through village-level Information Centres, Avert Society Mumbai, Galvanised the village community. Information Centres called "*Moniker Saiyukta"* (Sanskrit for "integrated"). it represent an integration of all relevant government departments, a convergence of various local- and district-level bodies, as well the mainstreaming of HIV/AIDS issues with the general health-related concerns of the rural community.

Madhya Pradesh: The list of Link Workers operating in each village is displayed prominently at the local Primary Health Centre (PHC) and Community Health Centre (CHC). In addition, all Link Workers in the state are a part of their respective Village Health and Sanitation Committee (VHSC).

Tamil Nadu: In Kanchipuram district a Public-Private Partnership (PPP) model is initiated, with private firms such as Hyundai and Saint Gobain making contributions in the form of HIV/AIDS banners and village-specific handbooks.

Karnataka: Village-level *Panchayats* have been actively involved in reviewing the implementation of LWS by interacting with Link Workers, as well as organising a structured review of the programme during VHSC meeting. In many villages, the *Panchayat* has also borne the cost of certain IEC activities, such as wall paintings and writings. In one district, the *Panchayat* was able organise and conduct health camps in villages where no proper health infrastructure existed by bearing the cost of travel for healthcare providers and counsellors.

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4.4 Stigma and Discrimination

4.4(a) Using Theatre to Reduce Stigma and Discrimination against MSM in Rural South India

Lotus Integrated AIDS Awareness Sangam, founded in 2000, is a membership organization that supports MSM in Kumbakonam and surrounding villages in Tamil Nadu, India. Lotus works with about 1,500 members, organizing membership meetings, providing counselling, and undertaking advocacy efforts to reduce stigma and discrimination and prevent HIV transmission.

Lotus recognized the potential power of theatre to promote positive social change. It developed a theatre program in and around its rural base in Tamil Nadu, India, aimed at changing harmful attitudes and practices preventing MSM and transgender persons from accessing legal redress through their municipal governments known as *panchayats*.

Lotus selected villages for the performances on the basis of the group's knowledge of where MSM resided and the willingness of panchayat leaders to have a performance in their community. In total, Lotus organized 75 performances of the play in three districts over the course of one year, reaching approximately 11,250 villagers.

4.4(b) Celebrating Those Who Care: A Radio Program by HIV-Positive Journalists

The Communication Hub (TCH), formed in 2007, harnesses communication to address a wide range of health and development issues, such as HIV and AIDS, reproductive health and sexuality, polio, tuberculosis, and sanitation.

TCH partnered with the Network of Maharashtra People Living with HIV (NMP+), to develop a 13-part radio serial to highlight the stories of people living with HIV and a significant person in their life who supports them.

In weaving these stories into a serial, the team included critical information on HIV and AIDS. The serial addresses misconceptions about HIV and people living with HIV and provides a means for the radio audience members to act on what they have heard. Episodes include information on available testing, care, and treatment services, as well as contact information for NMP+.

4.4(c) Ensuring Dignity and Rights among Female Sex Workers in Bangalore: A Community-Led Advocacy Campaign to Reduce Stigma and Discrimination

Project *Baduku* draws inspiration from the stigma and discrimination faced by FSWs. The project aimed to empower and build the capacity of women in sex work to challenge stigma and discrimination.

Project *Baduku* led advocacy efforts directed toward the general public and secondary stakeholders, such as police and health care workers, and toward the partners, family members, and neighbours of women in sex work. The campaigns sought to sensitize these populations about the issues women in sex work and people living with HIV face and to encourage change in societal attitudes and biases.

As part of this process, the project aimed to provide opportunities for (a) interaction between the sex worker community and stakeholders (for example, outside of hospitals and police stations); (b) intercommunity dialogue and discussions among women in sex work about experiences of stigma and discrimination; and (c) capacity strengthening in the sex worker community to strengthen processes related to decision making, management, implementation, and self-governance.

The project was envisioned and implemented by three support organizations for women in sex work in urban Bangalore - *Swathi Mahila Sangha, Vijaya Mahila Sangha*, and *Jyothi Mahila Sangha* - with technical support from the Swasti Health Resource Centre, a local nongovernmental organization (NGO

4.5 Planning Process of NACP-IV In continuation, with its mandate of inclusion and participation, the planning process for NACP-IV was widely consultative similar to that of NACP III. .

NACO conducted a series of national and regional consultations with civil societies, development partners, government departments, public and private sector partners, NGOs and networks. As part of this process, Technical Working Groups (TWGs) consultations were held on 17 thematic areas which are (i) Program Implementation and Organizational Restructuring; (ii) Finance management; (iii) procurement;(iv)Lab services; (v)STI/RTI; (vi) Condom Programming; (vii) Communication Advocacy and community mobilisation;(viii) GIPA stigma and ethical issues; (ix) mainstreaming and partnerships;(x) blood safety;(xi)ICTC/PPTC;(xii) Care, Support and Treatment (CST);(xiii) Strategic Information Management System (SIMS); (xiv) Gender, Youth and adolescence; and (xv) Targeted interventions.

4.5.(a) Regional Consultative Meetings

In continuation, its policy of wide consultations with all stakeholders at various levels, NACO facilitated 5 regional multi-stakeholder consultations involving key stakeholders from government departments, development partners, public and private sector partners, civil societies, NGOs and community networks were held with more than 400 participants for two days.

4.5(b) e-Consultations

To include wide range of consultations, NACO also initiated 'e-discussions'. The discussions titled "**Moving towards NACP-IV - Sustaining and Maximising Results."** was opened up in June 2011. Based on their experience of working in HIV/AIDS sector, inputs were invited on the following through e- consulations

1. What worked well under NACP-III, and Why?
2. What needs to be strengthened under NACP-IV, and Why?

E-discussion was open for two weeks. During the period, the participants gave inputs on areas need to be strengthened under NACP –IV.

These regional consultations and e discussions fed into the national consultations and provided recommendations for NACP IV and that was not limited to world bank supported NACSP.

4.6 Mainstreaming for Gender and Social Protection

The efforts of mainstreaming contributed to the mandate of gender and social inclusion , though the same was not supported by the World Bank .

- Formation of the National Council on AIDS represented by 31 Ministries. The main functions of the NCA are to generate a National level multi-sectoral response in the fight against AIDS.
- Formation of State Council on AIDS in 25 states. This has resulted in a number of states integrating concerns of PLHIV in developmental schemes such as ICDS, NREGS, pension scheme, nutrition schemes, and free transport to ART centres.
- Several policy initiatives have been initiated during NACP-III these include:
  - National policy on HIV/ AIDS and the World of Work ensuring non-discriminatory workplace policies and referrals/ linkages to services, has been approved by the Union Cabinet and roll out led by the Ministry of Labour & Employment.
  - The operational guidelines for Tribal Action Plan were finalized and shared with key stakeholders with roll out in 13 states
  - In order to address the vulnerabilities of women, guidelines and operational plan on "Mainstreaming HIV and AIDS for Women's Empowerment" has been prepared.
  - Draft National guidelines for GIPA have been developed in consultation with the various networks and development partners.

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- Strategic partnership with 31 ministries has resulted in a number of outcomes. Sensitisation on prevention programme was carried out among the workforce of all Ministries. With 11 ministries, specific actions were initiated for enabling environment. With six ministries, focus was on social protection; improvement of existing schemes for benefit of PLHIVs and new schemes for PLHIVs.
- To reduce the stigma & discrimination faced by People Living with HIV (PLHIV), training and sensitization programmes for different grassroots functionaries such as SHG, *Anganwadi* Workers, ASHA, ANM and members of Panchayati Raj Institutions were conducted across the country. PLHIV representatives were actively involved in these efforts. HIV and AIDS issues were discussed in over 73,000 *Gram Sabha* meetings.
- Training and sensitization programmes were also conducted for defence and para-military personnel, institutions attached to M/o Tourism, M/o Urban Affairs.
- Two successful phases of the Red Ribbon Express were run in collaboration with the Ministry of Railways. Ministries other than Health, such as Rural Development, Women & Child Development, Panchayati Raj, Education, and Youth Affairs participated in the activities both at the station and outreach level.
- Adolescence Education Programme in over 50,000 schools is being implemented in collaboration with M/o Human Resource Development. ICDS guidelines were modified to include CLHIV. In Panchayat *Mahila Evam Yuva Shakti Abhiyan* (PMEYSA) included HIV and AIDS in its agenda. *Saras Mela* across the country provided market access to products manufactured by people living with HIV.
- Provision of HIV and AIDS related services in railway hospitals, defence hospitals, ESI hospitals and establishment of ART centres and ICTCs on PPP model are examples of expanding services through mainstreaming. Significant progress have been made in Ministry of Defence and Ministry of Railways in terms of scaling up of services.There are several ongoing initiatives- engaging with insurance development regulatory authority to bring PLHIV within the ambit of health and life insurance products, convergence of NRHM, strengthening implementation of workplace policy and addressing the vulnerabilities of migrants.

"The guidelines state that women's vulnerabilities to HIV/AIDS are a result of unequal power relations between and among men and women in the society and therefore the guidelines on Mainstreaming Gender and HIV for Women's Empowerment"

Table 3: Increased Access to Social Protection Scheme for PLHIV

Category	Scheme	Agency
Health	Insurance	Ministry of labour ; Private Sector ;and Govt. of Rajasthan
Transportation	Free Transportation	Ministry of Surface Transport +States + Private sector

Nutrition	ICDS, *Antodaya Anna Yojana*, Nutritional support	Ministry of Women and Child Development, Ministry of Civil Supplies; Directorate of Women Development, Government of Nagaland and other states
Social Security	Pension Schemes	Ministry of Social Justice and Empowerment. Ministry of Women and Child Development, Ministry of Rural Development Government of Orissa, Gujarat, Goa, Tamil Nadu, Andhra Pradesh, APSACS, Dept of Women Development and Child Welfare, Government of Karnataka
Livelihood	MNREGS, SJSY	Ministry of Rural Development and Govt. of Gujarat
Housing	IAY, State govt. schemes	Ministry of Rural Development and Govt. of Orissa, Karnataka
Legal Aid		Ministry of Law and Justice
Education	Scholarships	Govt. of Rajasthan, Karnataka, Gujarat
Grievance Redressal	Grievance Redressal mechanisms at ART centres	NACO

Source: Working Group on Mainstreaming NACP-IV

The progress with related to social protection measures available at the time of Mid term review and at the end of NACP III indicate appreciable growth as shown below

Nature of social support	**Number of states providing social support**	
	During MTR	End of NACP III
Transport support to PLHIV for commuting to ART Centers	7	14
Nutritional Support for PLHIV	10	22
Financial assistance and Social Security Schemes	8	13
Legal AID	6	11
Safe Environment	6	10

4.7 Greater Involvement of People Living on HIV (GIPA

The involvement and participation of PLHIV from most at risk population enhances inclusion of marginalised and high risk groups in NACP, including positive women.

NACP-III provided for greater involvement of people with HIV by bringing them on board of important committees and forums including the following:

- National Council on AIDS (NCA) and State Councils on AIDS (SCAs)
- Technical Resource Groups (TRGs)
- Country Coordination Mechanism (CCM)
- Grievance Redressal Committees at the state level

PLHIVs participation is higher in the following:

- Training programmes;
- Advocacy workshops; and
- Outreach activities, as resource persons and positive speakers.

PLHIVs are also working as, providers under different components of the programme

- Counsellors;
- Peer and outreach workers; and
- Health care providers

As partners in mainstreaming, they managed for themselves and their networks special approvals under various welfare schemes; such as

- Free transport to ART centres,
- Supplementary nutrition,
- Widow pension scheme; and
- Legal aid

PLHIVs have formed their networks in most States and districts. In some states, these networks are managing Drop-in –centres, where services like psycho-socio support, counselling and referral services and linkages to welfare schemes are provided. Grievance Redressal Committees at state level address issues of stigma and discrimination against PLHIV particularly in the context of health care setting.

4.8 Gender

NACO developed an Operational Framework to address gender specific vulnerabilities to HIV during NACP-III. The guideline on Mainstreaming Gender and HIV for Women's Empowerment lays a strong emphasis on addressing the vulnerabilities of women to HIV through a multi-sectoral approach and by building up partnerships.

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4.9 Stigma and Discrimination

NACP III addressed the need to focus on stigma that prevails in different settings such as: self, family, community, health systems, educational facilities and workplaces**.**

The major initiatives taken during the NACP-III which challenged the issue of stigma and discrimination are as follows:

- Multi-media mass mobilization campaigns such as Red Ribbon Express (RRE) which involved positive networks for campaign outreach and generated a strong community dialogue on the issue.
- Spots on radio and TV with messages by celebrities on the issue of stigma and discrimination; special episodes on the issue of stigma in long format radio and TV programmes such as “Kalyani Health Magazine” and TV serial “*Kyunki Jeena Issi Kaa Naam Hai*”.
- Folk media performances in rural areas with focus on stigma and discrimination.(would provide more under this head)
- Sensitization of medical and para-medical staffs on stigma during training programmes; inclusion of stigma and discrimination components within the sensitization programmes for grassroots workers such as SHG, AWW, ASHA, ANM and members of PRI; advocacy and sensitization programmes for parliamentarians, legislatures, faith based leaders, judiciary, police and other stakeholders; media sensitization programmes for journalists on stigma free reporting.
- Involvement of PLHIV as positive speakers at various national and international forums, training programmes and advocacy workshops.
- Linkages established between various service centres and positive networks; setting up of Drop-in-Centres to provide platform for psycho-social support to PLHIV in the districts and to facilitate access to services.
- Formation of grievance redressal committees in the states to address the issue particularly in medical settings.
- Involvement of PLHIV in various mainstreaming programmes and in leveraging several Government welfare schemes to mitigate the impact of the epidemic on PLHIVs.
- Systems for prompt actions taken through concerned authorities in case of reports of stigma and discrimination.

The activities pertaining to mainstreaming, gender, GIPA and stigma and discrimination were not directly supported by the World Bank , but had notable contribution to enhancing gender and social inclusion in the prevention activities which are supported by the World Bank.

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4.10 Review of NACP-III:Targeted Intervention

Targeted intervention is one of the most important prevention programme in NACP for reaching most at risk population who are socially diverse and marginalised groups. Programme not only reached these groups for providing HIV prevention services but also capacitated marginalised communities with increased knowledge about epidemic, negotiating skills and access to services. Shared below are the few achievements under targeted intervention (TI) programme:

4.10(a) TI for Female Sex Workers

NACP –III has been able to successfully mobilize the community and helped FSWs take ownership of the program. Secondly, emphasis on the peer led outreach and structural intervention was instrumental for successful implementation of the strategy for FSWs. The quality of care improved manifolds over the previous two phases. NACP III reached 84% FSWs through TI projects.

4.10(b) TI for MSM

Various consultations on MSM acknowledge the efforts of NACO in addressing the issue of MSMs, It has been stated that "NACP is the only programme in the country which has shown the courage to respond to the health and development needs of MSM."

Despite a very planned and successful intervention, programme identified a certain barriers in Outreach services, thereby making reaching to the different typologies of MSM under NACP-III difficult Through targeted intervention projects 69% of MSMs were covered with various prevention services.

4.10 (c) TI for Transgeners and Hijra

NACP III recognized that "MSM" is not a homogeneous population. It acknowledges the unique HIV prevention, care, and treatment needs of Hijras and transgendered (TG) persons, and hence, treated them as a separate group.

NACP-III (2007–2012) has included "MSM and transgender" persons among the "core groups" for whom intensified HIV prevention and care programs are implemented. In some states (e.g., Tamil Nadu and Maharashtra) separate interventions for Hijras/TG are being implemented for some years.

4.10 (d) TI for Migrants

Migrants are a critical group because of their mobility and hence their role in the mobility of HIV infection. Their living and working conditions, sexually active age and separation from regular partners for extended periods of time predispose them to paid sex or sex with non-regular partners. Further, inadequate access to treatment for sexually transmitted infections aggravates the risk of contracting and transmitting the virus.

NACP- III reached nearly 2.8 million migrants in the country, through targeted intervention projects and work place interventions.

Hitherto, NACP-III carried interventions with migrants at their destination point, however, new strategy " National Migrant Strategy and Guidelines (2010)" provides for working with them at all points i.e. Source/place of origin, in transit and at destination.

4.10 (e) TI for Truckers

Truckers, like Migrants are a critical group because of their mobility and hence their role in the mobility of HIV infection. Their living and working conditions, sexually active age and separation from regular partners for extended periods of time predispose them to paid sex or sex with non-regular partners. Further, inadequate access to treatment for sexually transmitted infections aggravates the risk of contracting and transmitting the virus.

Interventions with truckers carried out by the NGOs under NACP mainly focused on long distance trucker driver (LDTs) and at transhipment site is the point of contact for intervention activities.

4.10 (f) TI for Injecting Drug Users

The National AIDS Control Organisation (NACO) has adopted the harm reduction (HR) strategy in NACP - III to prevent HIV amongst the IDUs through targeted interventions (TI) by non government organizations (NGOs). As per the interventions planned for IDUs, the program reaches out to the IDU by delivering harm reduction services such as outreach and needle-syringe distribution. Through this it has reached a significant proportion of estimated IDU population. Harm reduction is the key strategy for intervention among IDUs and their sexual partners, to reduce the risk of acquiring and transmitting HIV. Needle syringe exchange programme (NSP); 2) Opioid substitution therapy (OST); are two critical components of the strategy. Through TI projects 81% of IDU population is covered.

4.10(g) Capacity Building Initiatives

One of the four fundamental principles of NACP III was to strengthen the infrastructure, Systems and human resources in prevention, care, support and treatment programme at district, state and national levels.

To build the capacity of staffs working in the TIs, State Training and Resource Centres (STRCs) have been established. These agencies provide training on standardised modules developed by NACO for each component of the intervention..

Besides, Technical Support Units are in place at national and state level to provide technical handholding to TI projects. At the district level, A District AIDS Prevention & Control Unit (DAPCU) is set up in all A & B districts to provide management oversight to HIV and AIDS activities in the districts. The lowest NACO administrative structure, works with the district administration and programmes provided under the National Rural Health Mission (NRHM) with which the NACP will eventually converge.

NACO has strengthened the institutional capabilities by:

- Defining operational guidelines for divisions and SACS/DAPCUs and STRCs.
- Leveraging external technical / support units (TSUs, TSGs, TRGs and STRCs).
- Building strong technical expertise and capabilities by leveraging contractual staff.

There are currently 17 State Training Resource Centres in 21 States and 2 UTs. These agencies provide training to TI staffs using standardised modules.

TSGs were set up to plan and implement two priority areas - Condom promotion and Truckers TIs.

There are 18 TRGs (~200 experts) which have been formed to provide technical advice to divisions for all major programmatic areas. .

NACP-III had developed plans for building capacity of the programme managers and health personnel at the various levels, in leadership and strategies management, and technical and communication skills and also community level workers. The plan targeted all levels of care and health care organizations, CBOs and NGOs, as well as grass-root levels functionaries and workers of various government departments.

4.10 (h) Adolescence and Youth

Prevention of HIV is one of the important areas in the health of adolescents and youth. Offering adolescents and young people high-quality reproductive health services and ensuring that they have sound knowledge of sexually transmitted infections, empower them in their choices and behaviours. Making such services and knowledge available in early adolescence is important.

Adolescence Education Programme (AEP) The Adolescence Education Programme aims at providing adolescents with age appropriate information on the process of growing up during adolescence, HIV and AIDS, STIs and substance abuse. It focuses on the development of life skills as the most effective way to cope with the challenges of adolescence, thus striving to curtail the spread of the infections such as HIV and reduce the instances of substance abuse and other risky behaviours.

Red Ribbon Clubs (RRC) in Colleges: Over 13,000 RRCs have been formed in colleges primarily through NSS to enhance knowledge levels about HIV/ AIDS transmission, prevention and related services. The major activities at RRCs include competitions, quizzes, debates, essay writings etc. RRCs also promote voluntary blood donation in Colleges.

Initiatives for Out-of-School Youth: During NACP-III number of efforts have been done to address out-of-school youth. The Link Workers Scheme reached out to High Risk youth in rural areas of A and B category districts. Some states worked through NYKS youth clubs and NSS village camps to address out-of-school youth. The high risk and migrant youth were reached through TI interventions.

Other Initiatives: A large number of interventions simultaneously reached the youth in schools, colleges and out of-School/College. Spots were released on TV and radio specifically focusing on vulnerabilities of youth.

Another initiative was North-East Multi Media campaign in eight states of the north eastern region engaging youth through music and sports. Tamil Nadu organized youth carnival which attracted huge response from the youth and adolescents.

4.10 (i) Link Worker Scheme for reaching rural people

NACP-III has made efforts to reach high risk and vulnerable population in rural areas through the Link Workers Scheme. Currently these are being implemented in A &B category districts.
Presently, there are 219 districts under Link Workers Scheme. The LWS is an intensive rural-based intervention to reach marginalised groups untouched by the expanding urban interventions.
Link Workers provide services to the HRGs (FSWs, MSM, IDUs, and other vulnerable Sub-population (truckers, migrants, youth and women residing in rural areas) and infected and affected.

Achievements of the Link Worker Scheme

- Reached over 1, 50,000 HRGs (FSWs, MSMs and IDUs) in rural areas nationally.
- In addition, the Scheme also covers nearly 3, 00,000 Bridge Population members (truckers and migrants) and 20, 00,000 Vulnerable Population members (including, but not limited to, at risk women, spouses of HRGs, and out of school youth).
- The programme has also identified and covers over 37,000 people living with HIV (PLHIV).
- Over 75,000 HRGs have been tested for HIV under the LWS, with approximately 6,000 being tested in March 2011
- Either and over 5, 40,000 HRGs have sought treatment for STI symptoms under the LWS. This has been done by establishing linkages with existing services.
- 20000 condom depots have reportedly been established in the LWS villages. The uptake of condoms from these depots and direct distribution as reported is as high as 75 lakh.
- 8910 RRCs and 9517 VICs have been formed in the LWS

4.10(j) Communication and Advocacy

There are number of new and innovative initiatives were taken up during NACP-III. These are given below.

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- Synchronized roll out of mass media campaigns was undertaken, including mid-media, outdoor, IPC and ground mobilization, with the introduction of a national campaign calendar.
- Campaigns were implemented thematically and IEC materials were produced to cover different programme components and population segments.
- Three national level folk media workshops were held with the objective of standardizing messages and performances. The troupes and resource persons from different folk forms from across the country participated. A bank of 166 scripts covering 43 folk forms was developed. The resource persons trained at the national level are facilitating state level trainings and programme rollouts.
- Most of the states have started their own radio and TV programmes, intertwining messages with popular stories, phone-ins and discussions.
- Special episodes on HIV/AIDS were aired in Kalyani Health Magazine and a part of the DD serial "Kyunki Jeena Issi Kaa Naam Hai" was sponsored which incorporated HIV/ AIDS messages.
- Some notable initiatives at the state level include Dillu Dura in Tamil Nadu, using mass media supported by folk media, Ilavattam in Tamil Nadu to sensitize youth on HIV/ AIDS issues, Me Namaste and Be Bold in Andhra Pradesh to promote HIV/ AIDS services.
- A revised migrant strategy to guide communication efforts was designed.
- Legislative Forums were established in State Assemblies for stepping-up advocacy efforts.

4.10(k) ICTC/PPTCT

The achievements of ICTC / PPTCT programme interms of scaling up, convergence and strategies under NACP III are commendable. The number of standalone ICTCs have increased from 2185 ICTCs to 5246 ICTCs (up to March 2011).

1632 facility integrated ICTCs (F ICTCs) in public health settings as well as 670 ICTCs under PPP model were also established.

At present integrated counselling and Testing facilities are available at 24x7 PHCs in high prevalence states and up to CHC/ sub district level facilities in vulnerable states.

135 mobile ICTCs have been established for hard to reach populations and for regions with difficult terrain.

Counselling and testing of general clients includes testing of HRGs, STI patients, bridge populations (truckers / migrants), TB patients and walk in clients, other than pregnant women. The programme has shown a remarkable achievement in counselling and testing of

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general clients from 4 million tested in the year 2007 to more than 9.5 million in the year 2010-11.

NACP III which strengthened the overall quality of the ICTC component, improved access to services and boosted the uptake of services are as under

- Developing a standard National policy for Counselling &Testing for all testing facilities and setting up of strong quality assurance systems.
- Free counselling and testing services, linkages with TI NGOs,
- Outreach activity by ICTC Counsellors for motivating HRGs to access services, follow-up and linkages to care, support and treatment.
- Rolling out of EID through ICTCs has made a significant contribution to the PPTCT

  Programme.
- Intensified TB – HIV package rolled out in the country for improving HIV-TB collaborative activities and putting an increased number of persons - HIV-TB co-infection under care, support and treatment.
- Beginning convergence with NRHM and health systems with establishment of FICTCs, whole blood testing by RNTCP LTs and labour room testing.
- Establishment of *Saksham* GFATM R7 training institutes across the country for capacity building (training and counselling supervision) of counsellors working in various settings.

4.10 (l) PPTCT programme

The credit of the success under PPTCT programme goes to a dedicated workforce including various health care provides like doctors, counsellors, outreach workers and others and ability to partner with civil society.

Achievements of NACP-III:

- PPTCT reached 6.6 million pregnant women out of 27 million pregnant women.
- 16954 out of 43000 estimated HIV+ pregnant women were identified. Out of them11962 mother-baby pairs received NVP
- 9917 eligible pregnant women were offered CD4 testing, out of which 3969 (40%) were eligible for ART as their CD4 count was less than 350 cells/cmm.
- Out of the eligible pregnant women, 2265 (57%) were started on ART.
- It was able to saturate public health sector with testing and counselling facilities in high prevalence states.

- The program was able to design, disseminate and use effective IEC

4.10 (m) Care, Support and Treatment

The delivery of care and treatment services for people living with HIV/AIDS is provided through a three-tier structure. The various levels where HIV care and treatment is provided include:

1. Centre of Excellence (CoE) & ART Plus Centres
2. ART Centres
3. Link ART Centres & Link ART Centre Plus

ART Centres are also linked with Community Care Centres run by NGOs for a comprehensive package of services.

Achievements of NACP-III

- There are 306 fully functional ART Centres against the target of 250 by March 2012 Nearly 12.5 lakh PLHIV are registered and 420000 patients are currently on ART.
- 612 Link ART centre (LAC) have been established wherein, 26023 PLHIV are taking services
- There are 10 Centres of Excellence,
- 7 Regional Pediatric centres are also functional.
- 259 Community Care Centres across the Country

4.10 (n) Sexually Transmitted Disease and Reproductive Tract Infection Promoting Sexual and Reproductive health service is the cornerstone under the National AIDS Control Program III and Reproductive and Child Health (RCH II) of the National Rural Health Mission (NRHM) It promotes inclusion of MARPS and access to HIV/AIDS services under NACP. **Achievements under NACP-III**

- The programme under NACP III started with 544 STI clinics, mostly located in teaching and district hospitals. Realizing the huge burden of reproductive morbidity, especially among women and adolescents, department of Obstetrics and gynaecology was linked with Dermato-Venereology and the clinics were named Designated STI/RTI clinics (DSRC). The programme has been scaled to 1033 DSRC.
- Programme introduced pre-specified colour coded STI/RTI drug kits for introducing standardization in treatment and ensuring compliance to treatment.
- Counsellors were appointed at all Designated STI/RTI clinics with a primary objective of counselling STI/RTI clients on risk reduction, awareness of safer sex behaviours, follow up, linkage with TI projects and data management.

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- A set of training material was developed jointly with Maternal Health division to train medical officers, nursing personnel, laboratory technicians and counsellors; as well as doctors in private sector. A cascade model of training was adapted and NACO has created a pool of over 1000 resource persons at national, state, regional and district level.
- Convergence with NRHM was initiated and close working coordination developed with maternal health division for joint procurement of colour coded STI/RTI drug kits and roll out of services through sub-district level health facilities. 2441 doctors and 4949 paramedical staff have also been trained at the sub-district level health facilities.
- Regional STI training, research and reference laboratories (Regional STI centres) provide laboratory based support and evidence to the programme. Five of these centres, set up under the National VD control programme were revived and two additional Regional STI centres were established at Delhi and Baroda, taking the total number of Regional STI centres to seven.
- Programme partnered with the private sector, which was initially a client based approach, later changed to HRG focussed model across the country. Close to 4500 providers in private practice have been linked with the programme through TI NGOs to provide STI service delivery to the HRG.
- Programme has introduced supportive supervision and field level trouble shooting, which has improved reporting, minimized errors in recording, built the skills of providers and as a spill effect, many mentors have been developed in each state.

Chapter 6 Social Assessment of HIV / AIDS in Tribal Areas

6.1 NACP III had definite approaches and strategies to address various social and gender issues pertaining to HIV / AIDS control programme vulnerable groups including tribal population. , .However in keeping with the inclusive mandate of NACP, efforts were made to understand the reasons of vulnerability of tribal areas and address them accordingly .

- Tribal population is one of the priority Group under NACP III due to low awareness, remote location and poor access to health services.
- NACP III closely worked with Tribal Welfare Departments to implement an HIV/AIDS strategy through the health system by including programmes on HIV/AIDS prevention, care, support and treatment in their ongoing programmes.
- A social assessment conducted during NACP–III preparatory phase highlighted the factors of their vulnerability, low awareness, gender differences in the matter of treatment seeking behaviour in most of the states.
- Out of the total 192 ITDP areas 65 are falling in category A and B districts which itself is one of the indicator of their heightened vulnerability. It was decided that the TAP roll out should begin in these 65 ITDP areas falling in A and B category districts

6.2 NACP-III focus on Tribal Populations

Tribal population was one of the priority groups under NACP-III since they face multiple challenges due to low awareness, remote locations and poor access to health services. Based on a comprehensive understanding gained from stakeholder consultations and a social assessment for NACP III, the National AIDS Control Organisation jointly with Ministry of Tribal Affairs designed operational guidelines for Tribal Action Plan to improve the access of tribal people to information, prevention and comprehensive care and support under NACP-III. The action plan is tailored to three types of tribal situations:

1. Strengthening AIDS prevention and treatment services in the predominantly tribal north-eastern region.
2. Integrating HIV/AIDS related services into the programmes and structures of Tribal Affairs wings of government at various levels, through collaboration with officials of the Integrated Tribal Development Authorities (ITDAs) to improve prevention and treatment services in states, with designated tribal sub-plan areas, which have concentrated tribal populations. In both these sets of states, IEC materials will be translated in local dialect and local communication channels would be used to promote safe behaviour, increase access to condoms, and provide referrals to ICTC and ART services. These services will be provided free of charge to poor tribal people. Patients and attendants who travel to health centres for diagnostic or treatment services will be compensated for travel and related expenses.
3. Tribal people who are dispersed among non-tribal populations will be reached through mainstreaming efforts, particularly IEC, interventions for migrant workers, and other local initiatives.

Thus, in line with the NACP-III recommendation, a special strategy has been developed to work closely with the Tribal Welfare Departments in the states to implement an HIV/AIDS strategy specifically addressing tribal population. Out of the 192 Integrated Tribal Development Projects (ITDPs), 65 are in A and B category districts which were planned to be covered in first phase of intervention. The operational guidelines for Tribal Action Plan were finalised.

Activities done

- Prepared draft operation guidelines for rolling out of tribal action plan
- A National consultation workshop to finalize the operational guidelines for TAP.
- An amount of Rs. 5 lakh per ITDP has been allocated for IEC activities in tribal dialects and training of grass root health functionaries.
- The 13 states having ITDP areas in A and B Districts were requested to submit Tribal Action plan for their states. The plans of all thirteen states covering 65 ITDP areas have been prepared and approved. An amount of 3.31 crore approved as per details given on next page)

- The implementation has been initiated. The task force has been constituted and initial meetings have been done in 13 states (Gujarat, West Bengal, Orissa and Chattisgarh, Tamil Nadu, Karnataka Andhra Pradesh and Manipur. Assam, Tripura, Rajasthan , Madhya Pradesh. Maharashtra.)

Broad Components of Tribal Action Plan

1) State planning workshops : state level planning workshops were organized to build consensus and common understanding on taking the tribal action plan with the involvement and technical assistance of all development partners at GO/NGO/ INGO level.

2) **Capacity building –** of personnel involved in the implementation of tribal welfare plans/ tribal sub plans so as to build their capacity to mainstream HIV/AIDS issues in their ongoing activities. These capacity building activities are planned at the level of Tribal Research Institutes, ITDP areas, Staff of Ashram Schools and tribal Community leaders,

3)**Enhancing access to ICTC/ART centres**- NACP aimed to improve the access of HIV/AIDS services in tribal areas through building the capacity of Traditional healers and non-qualified private practitioners on syndromic management and reimburse cost of travel to ART centre and incidental expenses for the attendee and a companion. The states of Orissa, Rajasthan, are Gujarat is already providing travel expenses.

4) Preparation of IEC and learning material in tribal language; There is lot of variation in tribal languages used across states and there is little IEC and learning material in tribal language .Thus states would be preparing and translating IEC and learning material in tribal languages.

5) Outdoor and field activities

This component would cover conducting field level activities in haats weekly markets and other areas where Tribal people come together. The activities would cover puppet show, video shows, hoarding, wall painting etc

No direct evidence of special vulnerability of tribal population

A comprehensive mapping on risk factors associated with HIV/AIDS among tribal population in Gujarat was conducted through the State Tribal Research and Training centre. It was aimed at understand how the prevalence and positivity is different in the tribal block from the Non tribal blocks. This risk assessment indicated that "not all tribal blocks have higher positivity when compared to non Tribal blocks. **The evidence available through analysis of positivity in ICTCs of Gujarat done during vulnerability assessment is shown below;**

	Tribal Areas						Non Tribal Areas					
Apr to Sep 2010	**General**			**PPTCT**			**General**			**PPTCT**		
District	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**
Banaskantha	2596	16	**0.62**	1218	1	0.08	12549	347	**2.77**	12121	24	**0.20**
Dahod (All tribal)	14204	97	**0.68**	12957	8	**0.00**	0	0	**0.00**	0	0	**0.00**
Navsari (All tribal)	10478	177	**1.69**	7660	9	**0.00**	0	0	**0.00**	0	0	**0.00**
Surat	8589	147	**1.71**	12571	12	**0.10**	40380	1101	**2.73**	17905	70	**0.39**
Vadodara	2862	18	**0.63**	4102	3	**0.07**	14732	581	**3.94**	12025	34	**0.28**
Grand Total	**38763**	**456**	**1.18**	**38663**	**33**	**0.09**	**67661**	**2029**	**3.00**	**42051**	**128**	**0.30**

Assessment and learning from Tribal Action Plan

It must be understood that Tribal population in India is not a homogenous groups. Different tribal groups in different states have different reasons of vulnerability which may be due to migration, acceptance of polygamy,or lack of awareness , lack of health facilities etc .

The social assessment has examined the strategic planning of NACO and the concerned SACS as a part of NACP-III. The assessment has also considered the Tribal Action Plans (TAPs) consequently prepared by the states where a significant tribal population exists. NACP intends to improve on the service delivery front, synergizing with NRHM.

One of the major learning from the risk and vulnerability assessment was that **there is no specific vulnerability among the tribals based on the ethnicity but due to other factors dicussed above.** The finding of the vulnerability assessment done on pilot basis in Gujarat gave us rich inputs for further actions in our approach towards tribal population.

- Tribal population is not a homogenous population
- Tribal population in different geographical locations have different vulnerability factors
- Generalised approach for all tribal population is not the best strategy to go about addressing the need of this section of population
- Having separate and specific approach for tribal population may add to the further stigmatisation of this section of population
- Addressing needs of tribal population through targeted interventions according to their vulnerability for prevention of HIV/AIDS is a effective tool which helps in preservation of their cultural identity and maintaining the sanctity of tribal culture valued by this section of population .

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- As most of the ICTC and ART centres that cater to tribal areas are located in small towns such as Block or District headquarters for logistic convenience, these locations also cater to the non-tribal populations. Having a segregated data for tribal population was not required in view of the need to maintain the cultural identity nor feasible in view of the mixed population in certain geographical areas.

6.1 Social Assessment for NACP III

A study conducted before NACP III on vulnerabilities associated with HIV/AIDS among tribal people in India indicated that awareness and knowledge regarding Sexually Transmitted Infections (STIs) and HIV/AIDS was low among tribal people. Only 38.6 percent of women belonging to scheduled tribe in the age group 15-49 years had heard about AIDS as compared to 55.3 percent of scheduled caste, 58.5 percent other backward castes and 72.7 percent of women from higher castes.

Knowledge about prevention methods, as per the above cited report, also revealed that Scheduled Tribe women and men were least aware of each of the three means of prevention: delaying sexual debut among young persons (abstinence), limiting the number of sex partners/staying faithful to one partner (being faithful), and use of condoms (the ABC approach).

The vulnerability assessment conducted during the NACP III in Gujarat sharpened the approach of NACO towards tribal population . This assessment highlighted that **there is no specific vulnerability among the tribals based on the ethnicity but due to other factors such as migration, lack of awareness, difficult access of health services. These finding feed to the future strategy to addresss this population**

The following were specific approaches for the formulation of Tribal Action Plan:

i. Assessment of HIV/AIDS vulnerability and availability of HIV services.

ii. Based on aforesaid assessment which clearly highlighted that there is no specific vulnerability among tribals, formulation of Action Plan and identification for appropriate response.

iii. Implementing activities designed to address specific needs of tribal areas/communities as highlighted by study done in Gujarat

iv. Mainstream HIV/AIDS activities in the schemes/programs/structures targeted at the tribals & build their capacities to do so on a sustainable basis

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v. Strengthening linkages among the Tribal, Health & HIV/AIDS sectors for a more sustained response to HIV/AIDS

For ease of planning and processing of the proposals, different activities constituting them have been categorized in manner similar to that of NACP III Strategy and Implementation Plan document.

In order to facilitate the implementation of the NACP Tribal Action Plan, a set of guidelines have been developed by NACO . . The elaborate guidelines thus developed were designed to facilitate the state governments in the preparation of State Level Tribal Action Plans for their respective states. These guidelines were discussed in detail with the state representatives from the departments of tribal welfare, Tribal Research and Training Institutes and other relevant stakeholders. At the central level, the Ministry of Tribal Affairs and NACO are designated as the lead role players to coordinate and collate the state TAPs.

The Tribal Action Plan has already been rolled out in all 65 ITDP areas in 62 'A' and 'B' category districts across thirteen states — Andhra Pradesh, Gujarat, Tamil Nadu, West Bengal, Karnataka, Chhattisgarh, Orissa, Rajasthan, Manipur, Assam, Madhya Pradesh, Maharashtra and Tripura . State level workshops were held in all states for joint planning between Department of tribal affairs and SACS which the key participants included TRI officers, NGOs working on Tribal issues, *Ashram Shala* Officers and DAPCU officers. Training of trainers has been done to create a pool of trainers for capacity building of all personnel involved in tribal development in most of the states. Further training at field level is in varied stages across the states. The TAPs developed by the states of Tamil Nadu and Gujarat may be mentioned here as examples of state efforts. The TN SACS, in collaboration with the state Tribal Welfare Department has conducted advocacy meetings to sensitize government officials in which officials from the head quarters and all district officials of *Adhidravida* and Tribal Welfare participated.

Under the TAP, Tamil Nadu State AIDS control Society also conducted training programs for folk performers on basics of HIV / AIDS, service availability and basics of street theatre performances, refresher training for folk performers, ToT program for master trainers from districts and training for mobile out-reach teams.

The Gujarat SACS has also undertaken similar activities under the TAP by forming a Task Force on HIV/AIDS Action Plan for tribal areas of Gujarat State. A state level workshop was held on launching of "Tribal Action Plan" in which the key participants included TDD officers, TRI officers, NGOs working on Tribal issues, *Ashram Shala* Officers, DAPCU officers & GSACS officers.

Other major activities included under the TAP were training of trainers (ToT) of TRI officers and other functionaries working in tribal areas	**Tribal Areas**	**Non Tribal Areas**

on tribal action plan components, proposed activities, HIV/AIDS etiology, vulnerability factors and role of TRI in tribal action plan, training of PRI members at *Banaskantha.*												
Apr to Sep 2010	**General**			**PPTCT**			**General**			**PPTCT**		
District	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**	**Tested**	**HIV +ve**	**% HIV +ve**
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Available reports and other documents for North East region are on tribal communities as, the current social assessment looks at understanding the tribal perspective from the other parts of the country.

However, a social assessment on HIV / AIDS would be deemed incomplete without a mention of the NE tribal states. The states of Arunachal Pradesh, Meghalaya, Mizoram and Nagaland have been identified by NACO as tribal majority states where 14 districts out of 42 are tribal districts falling in category A and B. Among the other states, Assam has 1 district, Manipur has 5 and Tripura has 1 district out of a total of 36 districts across these 3 states.

The State AIDS Control Societies (SACS) of Andhra Pradesh (AP) and Chhattisgarh have synchronized their operations with the Departments of Tribal Welfare and the Tribal Cultural Research & Training Institutes (TCRTIs) in these states. At the district level, the program implementation units are well established and synchronize their activities with the Health Department. While the AP program is implemented with active association of NGOs such as the Ramakrishna Mission, the Chhattisgarh program is implemented with an active involvement of the state TCRTI.

As part of the social assessment exercise, and in addition to a review of published documents and reports, detailed discussions with key functionaries from stakeholder institutions such as

SACS and the Tribal Welfare Department were held to understand the perceptions and actions of these stakeholders in addressing tribal related issues.

Some of the critical issues that had emerged during interactions with the state and district level stakeholders are presented below.

6.3.1 Vulnerability

There are no specific vulnerabilities arising due to the fact that they are tribal populations as observed from the findings of Gujarat study. However, because these communities are in geographical areas where there is low levels of awareness, limited access to health care services along with factors related to migration, their vulnerability increases indirectly. The reasons of vulnerability were however state specific like migration, low level of awareness, prevalence of female sex work, poverty, low media reach etc

NACP III has made efforts to address these vulnerability factors through inclusion of tribal people , where ever applicable, in Targeted Intervention projects for migrants, female sex workers, Men have Sex with Men, Injecting drug Users, organising special folk programmes in tribal languages, preparing IEC in tribal languages , etc

6.3.3 Communication strategy for tribal population

In the above two states IEC materials have been translated in tribal languages to address issues related to cultural identities of tribal communities. Chhattisgarh has developed separate posters for four different tribal dialects. Andhra Pradesh has also prepared ribal specific IEC materials. The Tribal Cultural Research and Training Institute (TCRTI), Hyderabad has designed IEC materials with words from the *Sugali, Kapu* and *Savara* (tribes of Andhra Pradesh) dialects with Telugu script was used to print posters and other materials. These materials are currently being used during the time of this assessment. A similar approach is followed in other states with exclusive tribal groups.

Considering the geographical spread of communities, an increase in the number of resource persons to undertake awareness generation and other public contact activities are engaged..

6.3.4 Access to Services and Utilization

Provision of outreach services and the network of facilities for testing and treatment appear to be satisfactory in the above two states. However, accessing treatment still appears to be a hindrance to many tribal PLHIVs. AP Government and another thirteen State Governments have provided free bus passes to the HIV+ and one accompanying person to attend the ART sessions at the treatment centres. The free bus pass program runs into some hurdles in states where there are only private bus services.

As most of the ICTC and ART centres that cater to tribal areas are located in small towns such as Block or District headquarters for logistic convenience, these locations also cater to the non-tribal populations. Having a segregated data for tribal population was not required , not feasible also.

6.4 Summary and Conclusion A review of critical social parameters influencing key program performance measures like awareness about HIV, access to services, utilization of services, etc., in tandem with the efforts put in by NACO, the SACS and other agencies reveals that regular coordination mechanism of the key role players results in maintaining the focus on vulnerable populations and providing efficient services. The Chhattisgarh example, where the Tribal Welfare Department, the Tribal Cultural Research and Training Institute (TCRTI) and SACS have a well-knit working relationship, shows the preparedness of the state in meeting their set objectives. This avoids replication of efforts and an optimal use of resources.

NACP III efforts, based on the Gujarat vulnerability assessment, indicate that targeted interventions, networking and mainstreaming for HIV/AIDS in tribal areas had yielded positive results. NACP should continue with the same approach and strategy as part of integration efforts in the programme in all relevant States.

Chapter 7: Key Issues and Challenges

According to recent estimates, the HIV prevalence overall in the country has come down, but new pockets have also emerged.[4] Herein, issues and challenges that are emerging are discussed, but the discussion is limited to the social inclusion aspect only, as per the mandate of Social Assessment document. The key issues and challenges emerged are:

Coverage

The changing face of the behaviour and practices among high risk groups has thrown up challenges to the HIV response in TI programmes. These challenges are ensuring coverage, service access and engaging with community.

- There is a need to improve the coverage of sex workers who operate in non-traditional forms such operating through mobile phones, home based sex work etc.
- There is a need for address the dispersion / mobility of sex workers in some locations.
- Out reach needs to be modified to focus more in new and young FSW.
- Services for IDUs need to be scaled up with specific focus on female IDUs
- Coverage of migrants particularly married migrants need to be increased through revised migrants intervention strategy. Comprehensive program developed for source level to be mainstreamed a the district level to ensure coverage of returnee migrants and linkages to services should be assured where required

Care and Support (C&S)

- Competency based training for health providers at different levels.
- Integration of services can bring in scale up of services and reach in unreached areas.

[4] Annual Report NACO 2010-2011

Stigma and Discrimination

- Sensitisation and involvement of AWW, ASHA, ANM, SHGs and PRIs may address gender stereotypes and S&D at community level.
- Gender sensitive Health service provisions may be ensured by training medical and para-medical staff.
- Addressing stigma & discrimination at health care settings by sensitization of the health care providers and advocacy with stakeholders.

Enabling Environment

- Sensitization and capacity building of DIC staff may be done to address gender issues and address vulnerabilities & discrimination against WLHIV.

Chapter 8 Recommendations

Some of the suggested strategies which can help overcome challenges are discussed here in this chapter**:**

Scaling up and monitoring quality of Coverage

- Peer educator model works and TI should adapt the PE model to suit the local context like geographical dispersion of the SWs, density and typology.
- Variable strategies for different type of HRGs should be developed.
- Female IDU vulnerability needs to be addressed through existing IDU interventions.
- In view of the increasing vulnerability among the migrants, the coverage of this groups has to be increased through the existing source, destination and transit interventions.

Enabling Environment

- Formation of support groups may be promoted.
- Sensitization and capacity building of DIC/CCC staff may be done to address gender issues and address vulnerabilities & discrimination against WLHIV.

Care, Support and Treatment

- Competency based training for health providers at different levels.
- Integration of services can bring in scale up of services and reach in unreached areas.

STI Management

Community preferred programme linked STI clinics at the TIs should continue.

Stigma and Discrimination

- The training components under AEP and RRC should reinforce messages against stigma and discrimination.

IEC campaigns and specific IEC messages on reducing stigma should be carried out.

Mainstreaming

Activities initiated mainstreaming with the support of UNDP as mentioned bellow needs to strength further.

- Linkages to Sexual and Reproductive Health services should be comprehensive in nature to cover departments of gynae, STI, ANC family welfare, ARSH and post

partum facilities in the given hospital, through common windows/ platforms wherever possible.

- Training and sensitization programmes of frontline workers such as AWW, SHGs and women PRI members started in NACP-III may continue for effective mainstreaming and convergence.
- Panchayati Raj Institutions and other forms of effective mediation at community level may be strengthened to address stigma and legal issues.

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Annexure – A: List of Documents Consulted

Sl. No	TITLE OF THE DOCUMENT
1.	Annex I- Communication Matrix
2.	Lab Services Report
3.	

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Annexure – B: List of persons contacted in Andhra Pradesh and Chhattisgarh for the Social Assessment Project

	Name of the Contact	**Designation**
	Mr. Partha Sarathy	PD, APSACS
	Ms. Nirupama Rao	PO, Mainstreaming, APSACS
	Mr. Venkateswara Rao	DD, IEC, APSACS
	Dr. JC Reddy	JD. Basic Services, APSACS
	Dr. S. Ram Mohan Rao	SPM, Tribal Welfare
	Mr. BV Balayogi	JD, Tribal Welfare
	Mr. V. Ch. Veerabhadrudu	Additional Director, Tribal Welfare,
	DAPCU – East Godavari	
	Dr. Pavan Kumar	DACO, East Godavari District, AP
	Mr. G. Adilingam	DPM, DAPCU, East Godavari
	Mr. C.H. Hanumantha Rao	Counsellor, ICTC, Rampachodavaram
	Dr. J. Narasinga Rao	Med. Supdt., Rampachodavaram
	K. Rajanna Dora	Tribal Outreach Worker, Rampachodavaram
	Ms. S. Nagamani	Tribal Outreach Worker, Rampachodavaram
	Dr. S.K. Bijhwar	Additional Project Director, CGSACS
	Dr.T. K. Vaisnav	Joint Director, TRI
	Mr G.M. Jha	Assistant Director, TRI
	Dr. Anil Virulkar	Research Assistant, TRI
	Dr. V. B. Agrawal	Joint Director, Blood Safety, CGSACS
	Mr M.K. Jnaghel	Joint Director, IEC, CGSACS
	Mr Ajay Kumar Singh	Consultant, CSM, CGSACS
	Mr. S. Naqvi	PO, Mainstreaming, CGSACS
	Tribal Representatives	Trainees at Gurur, Durg Dist., Chhattisgarh

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