Operational Guidelines for Employer Led Model

October 2013

Department of AIDS Control

OPERATIONAL GUIDELINES for Employer Led Model

October 2013

National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

सत्यमेव जयते

लव वर्मा
सचिव
Lov Verma
Secretary

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
एड्स नियंत्रण विभाग
राष्ट्रीय एड्स नियंत्रण संगठन
6वां तल, चन्द्रलोक बिल्डिंग, 36 जनपथ, नई दिल्ली -110001

Government of India
Ministry of Health & Family Welfare
Department of AIDS Control
National AIDS Control Organisation
6th Floor, Chandralok Building, 36 Janpath, New Delhi - 110 001

FOREWORD

India has been a global success story in the containment of the AIDS infection. The prevalence of the infection has declined by around 57% over the last decade. However, due to its huge population India has still 2.1 million people living with HIV/AIDS, the third largest in the world. Studies suggest that labourers in the informal sector are at heightened risk and vulnerability of disease. In such a scenario, employers not only have the responsibility to act, but also an opportunity to play a crucial role in limiting the spread of the HIV/AIDS epidemic, particularly within their own workplace. Employers in industries with higher vulnerability can contribute significantly in mitigating the impact of the epidemic by taking some simple steps to ensure that their own workforce is free from HIV.

As a comprehensive strategy to reach out to migrants, the national program proposes interventions at source of origin, transit and destination points. There are migrant interventions implemented through NGO-led Targeted Interventions at destination points. However a far larger number of migrants are linked with various industries in the organized and unorganized sectors as contract or informal workforce.

The National HIV and AIDS program envisages reaching the migrant informal workforce linked with industries through the Employer Led Model by integrating HIV and AIDS prevention to care program within existing systems and structures of the industries. Employer-led initiatives provide an opportunity for enhancing access of the vulnerable workforce to HIV prevention, care and support program to reduce their risk and limit the spread of HIV epidemic.

I urge all public-spirited employers to come forward and adopt our carefully formulated Employer Led Models to defeat the epidemic, once and for all.

Lov Verma
Secretary
Department of AIDS Control
M/o Health & Family Welfare

6th Floor, Chandralok Building, 36 Janpath, New Delhi -110001, Phones : 011-23325331, Fax : 011-23731746
E-mail : secy.dac@gmail.com

Aradhana Johri, IAS
Additional Secretary
Department of AIDS Control, NACO, Ministry of Health and Family Welfare, Government of India

PREFACE

There is increasing evidence and growing recognition of the role of migration/mobility in the spread of HIV infection in India. Of the total 385 million workers in India, 93% are in the informal sector and most of them are migrants, either interstate or intrastate (within districts from rural to urban). A large proportion of informal seasonal workers are employed in industries such as, construction, manufacturing units, textile industry, leather industry, mines and quarries, agriculture, food processing, etc.

HIV affects people in the productive age group of 15-49 most and therefore has an impact on informal workers thereby affecting the economy of our country. HIV among informal workers may lead to a huge economic impact on the industries and requires timely intervention. Employers can play a crucial role in limiting the spread of the HIV, particularly among the formal and informal workers employed by them.

The Companies Act 2013 with provisions for 2% of profits being used for CSR, offers a unique opportunity to the corporate sector to enter into a win-win situation. Since the work force of industry is most vulnerable to HIV /AIDS, activities by industries for using CSR funds for risk reduction, etc., of its non-formal work force will lead to increased productivity of the work force as well as qualify for CSR.

Department of AIDS Control is already reaching out to migrant informal workers through specific interventions. Now, the Department has taken a strategic step in this direction by designing interventions or an Employer Led Model (ELM). These interventions will primarily be led by employers for their workforce to reach out to migrant informal workers in organised and unorganized sector industries, providing them with HIV/AIDS prevention to care services. Detailed Operational Guidelines have been developed to guide State AIDS Control Societies (SACS), Technical Support Units (TSU) and District AIDS Prevention Control Unit (DAPCU) officials and employers, in organized and unorganised sectors, to cohesively work towards forging partnerships under the ELM.

I am confident that effective implementation of this Model will help us reach out to the migrant informal workers and address their vulnerability to HIV/AIDS. The department would like to acknowledge the support of USAID and PIPPSE project teams for developing these guidelines.

(Aradhana Johri)

9th Floor, Chandralok Building, 36 Janpath, New Delhi -110001, Phones : 011-23325343, Fax : 011-23325335
E-mail :aradhana.johri@nic.in

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Abbreviations

AAP	Annual Action Plan
AD	Assistant Director
AEP	Adolescence Education Programme
AIDS	Acquired Immuno-Deficiency Syndrome
AITUC	All India Trade Union Congress
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
ASOCHAM	Associated Chamber of Commerce and Industry of India
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Unit
BEST	Brihanmumbai Electric Supply and Transport
BS	Blood Safety
BSC	Blood Storage Centre
BSD	Basic Services Division
BSS	Behaviour Surveillance Survey
CBO	Community Based Organisation
CBWE	Central Board of Worker's Education
CC	Cordination Committee
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CEO	Chief Executive Officer
CII	Confederation of Indian Industreis
CLHIV	Children Living with HIV
CMD	Chairman and Managing Director
CMIS	Computerised Management Information System
CoE	Centre of Excellence
CSM	Condom Social Marketing
CSMP	Condom Social Marketing Programme
CSR	Corporate Social Responsibility
CST	Care, Support and Treatment
CVM	Condom Vending Machine
DAC	Department of AIDS Control
DAPCU	District AIDS Prevention & Control Unit
DD	Deputy Director
DDG	Deputy Director General
DGET	Director General of Employment and Training
DIC	Drop in Centres
DLN	District Level Network
DoLE	Department of Labor and Employment
DOTS	Directly Observed Treatment Short-Course Chemotherapy
ELM	Employer Led Model
EQAS	External Quality Assessment Scheme
ESCM	Enhanced Syndromic Case Management
ESIC	Employee State Insurance Corporation
FC	Female Condom
FGD	Focused Group Discussion
FHI	Family Health International

FICTC	Facility Integrated Counseling & Testing Centre
FICCI	Federation of Indian Chambers of Commerce and Industry of India
FRU	First Referral Unit
FSW	Female Sex Workers
GIPA	Greater Involvement of People with HIV/AIDS
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
HR	Human Resource
H&S	Health and Safety
IBBS	Integrated Biological & Behavioural Surveillance
ICF	Intensified Tuberculosis Case Finding
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
IL&FS	Infrastructure Leasing & Financial Services Limited
INR	Indian National Rupees
JD	Joint Director
KABP	Knowledge, Attitude, Behaviour and Practices
LAC	Link ART Centre
LFU	Lost to Follow-up
LT	Laboratory Technician
LS	Laboratory Services
LWS	Link Worker Scheme
M & E	Monitoring and Evaluation
MARE	Most at Risk Economic Sectors
MARP	Most at Risk Population
MBBS	Bachelor of Medicine and Bachelor of Surgery
MbPT	Mumbai Port Trust
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOLE	Ministry of Labour and Employment
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCEUS	National Commission for Enterprises in the Unorganized Sector
NGO	Non-Government Organisation
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NSC	National Statistical Commission
NSSO	National Sample Survey Organisation
NTSU	National Technical Support Unit
OI	Opportunistic Infections
OPD	Out Patient Department
ORT	Oral Rehydration Therapy
PD	Project Director
PEP	Post-Exposure Prophylaxis
PIPPSE	HIV/AIDS Partnerships: Impact through Prevention, Privet Sector and Evidence Based Programming
PLHIV	People Living with HIV
PPP	Public Private Partnership
PPT	Power Point Presentation
PPTCT	Prevention of Parent to Child Transmission

PSU	Public Sector Undertaking
RC	Regional Co-ordinator
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojna
RTI	Reproductive Tract Infections
SACS	State AIDS Control Society
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SMO	Social Marketing Organisation
SOP	Standard Operating Procedure
SSI	Small Scale Industry
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
STRC	State Training & Resource Centre
TAC	Technical Advisory Committee
TB	Tuberculosis
TG	Transgender
TI	Targeted Intervention
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
USAID	United States Agency for International Development

Introduction to Operational Guidelines

The fourth phase of National AIDS Control Programme (NACP IV) proposes an Employer Led Model (ELM) to reach vulnerable informal workers in organized and unorganized sectors.

The operational guidelines for ELM provides broad methodology and implementation strategies for reaching out to vulnerable workforce linked to industries with HIV/AIDS prevention to care programme. In preparing these guidelines, thought has been given to industry-specific variations in systems, structures, resources and needs that may influence the rollout of ELM. However, implementers are urged to conceptualise the 'how' part to best respond to the needs, processes and resources unique to specific industries.

While there have been several models to reach out to informal workers, this operational guideline is restricted to implementation of ELM interventions under NACP IV. The ELM will be feasible inindustrial sectors which have certain systems and structures such as company management, association, federation, society, contractor and subcontractor mechanisms that can be leveraged for implementation of the model.

Purpose of Operational Guidelines

Broad operational guidelines for ELM have been designed to present a framework for what and how to implement. These guidelines detail out the objectives, strategies, models and implementation steps along with tools to support the implementation of ELM.

Target Audience

This operational guideline is targeted at SACS, TSU and DAPCU officials, programme managers in NGOs and employers in organized and unorganized sectors who intend to implement ELM.

Background and Rationale

SECTION 1

1 Background:

India has the third largest population living with HIV globally. The country has an estimated 2.1 million people living with HIV and AIDS and majority of the infections are in the most productive age group of 15-49 years[1].

As HIV and AIDS affects the most productive age group, the industrial sector stands most vulnerable to HIV/AIDS. There is increasing evidence and growing recognition on the vulnerability of migrant informal workers linked with industries to HIV infection. More ever since the HIV infection goes unnoticed for years together, it's difficult to know the exact magnitude of HIV/AIDS. The Global experience shows that investments in prevention of HIV/AIDS at the country level as well as individual enterprise level are more cost effective then care and treatment.

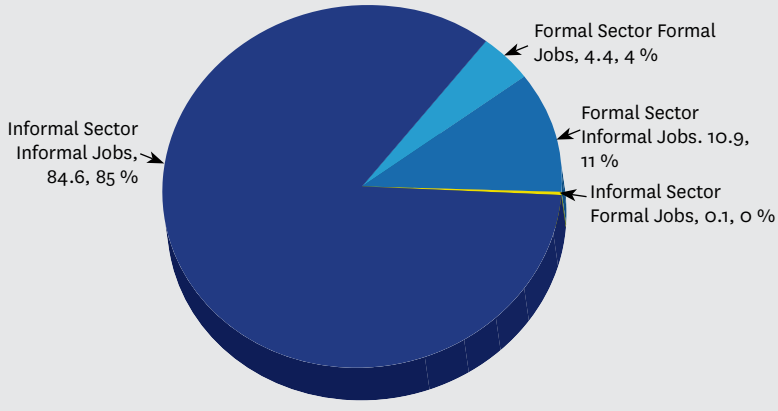
93 percet of total work force in India is in Informal Sector. Many workers are migrants and hired on a daily or seasonal basis, for short stretches of time. Many work in low-skill activities, often as contract workers and supply chain workers, in the organized sector or within small, medium enterprises and unorganized industries

HIV and AIDS differ from other illnesses in terms of unprecedented impact on socio-economic development that it has. The economic and social impact of HIV is not uniform, yet wherever it strikes, it affects individuals, communities, businesses and economic sectors, relentlessly eroding human capacity, productivity and prospects. The scale of the problem is beyond the reach of Government alone and there is need for multi-sectoral response to stabilizing the epidemic and its negative impact on the socioeconomic fabric of the country.

1.1 Changing pattern of work Scenario in India

Today, nine out of every ten workers in India are employed in the informal economic sector[2]. It is estimated that there are approximately 100 million migrants in the country working in various economic sectors[3], including private and public sector companies also even in the organised and unorganised industry. According to the National Statistical Commission

Percent Distribution of Formal and Informal Sector Jobs, India (2004-05)



Source: National Statistical Commission, 2012

[1] NACO-HIV Sentinel Surveillance, 2010, HIV estimates
[2] National Commission for Enterprises in the Unorganised Sector
[3] Deshingkar, Priya., Shaheen Akter, 2009, Migration and Human Development in India, Available at http://hdr.undp.org/en/reports/global/hdr2009/papers/HDRP_2009_13.pdf

(NSC) unorganised (informal) sector constitutes a pivotal part of the Indian economy NSSO (2010-11),

1.2 HIV/AIDS and Vulnerabilities of Migrant Informal Workforce

The public and private sectors in India employ 385 million workers[1], of which 93 percent are informal workers[2]. The top six sectors employ 79 percent of the workforce which include agriculture, manufacturing and construction, textiles, tobacco and mining[3]. Many of these are migrants and hired on a daily or seasonal basis, for short stretches of time. Many work in low-skill activities, often as contract workers and supply chain workers, in the organized sector or within small, medium enterprises and unorganized industries. There is increasing evidence and growing recognition of the vulnerability of these informal workers to HIV infection and importance of migration/mobility in the spread of HIV.

- Examining HIV-risk behaviours among contracted and non-contracted male migrant workers in India, Saggurti and others found that contracted labourers were significantly more likely to report HIV-risk behaviour than non-contracted labourers (38 percent reported sex with either a sex worker or non-spousal, unpaid female partner in their places of origin over the last 2 years[4])
- Recent studies on new HIV infection indicate that migration is one of the important drivers of the epidemic in low-prevalence states. An analysis of 87,613 ANC blood samples in 8 low prevalence states (Uttar Pradesh, Bihar, Orissa, Jharkhand, West Bengal, Chhattisgarh, Madhya Pradesh and Rajasthan), indicates that migration increases the risk of spousal transmission by 40 percent[5]
- Socio-demographic study across three important corridors of migration Ganjam in Orissa to Surat in Gujarat, Azamgarh in Uttar Pradesh to Mumbai in Maharashtra and Darbhanga in Bihar to New Delhi and the NCR indicates that the proportion of HIV positivity among females attributed to male migration is 35-55 percent[6]
- An assessment of industrial sectors in Karnataka, which engage informal workforce on a large scale, revealed that mining, garment/textile, sugar, construction/infrastructure and fishing industries were at higher HIV risk compared to other sectors (Halli, et al, 2009)
- The Sentinel Surveillance 2010, reports that truckers, unskilled workers and factory workers are amongst top categories of migrants and truckers tested positive for HIV[7]

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[1] Economic Survey 2004-05

[2] Informal worker – According to National Commission for Enterprises, the unorganized sector uses terms such as 'organized' and 'unorganized' in India, which are internationally referred to as 'formal' and 'informal'. According to NCEUIS, the unorganized sector consists of all unincorporated private enterprises owned by individuals or households, engaged in the sale and production of goods and services, operated on a proprietary or partnership basis and with less than 10 total workers". The commission defines informal/unorganized workers as: "Unorganized workers consist of those working in the unorganized enterprises or households, excluding regular workers with social security benefits, and workers in the formal sector without any employment/social security benefits provided by employers" (NCEUIS, 2007)

[3] Economic Survey 2004-05

[4] Policy Strategy and operational plan, HIV intervention migrants NACO 2010

[5] Population Council, Saggurti et al, 2008.

[6] NACO, UNDP, 2011

[7] NACO, HIV Sentinel Surveillance, 2010

- HIV-positivity rates among male and female migrants from Uttar Pradesh, tested in Thane (Maharashtra) ICTC, were 9.1 percent and 7.9 percent, respectively. Similarly, male and female migrants from Andhra Pradesh, tested in Thane ICTC, had a prevalence of 23.8 percent and 16.4 percent, respectively[8].

1.3 Migrant Strategy in NACP

Migrants bear a heightened risk of HIV infection which results from the condition and structure of the migration process. Available evidence suggests that migration might be responsible for the spread of HIV epidemic in high-out migration states such as Uttar Pradesh, Bihar, Rajasthan, Orissa, Madhya Pradesh and Gujarat; this now accounts to 41 percent of new infections[9].

NACP IV envisages accelerating reversal of the epidemic and integration of HIV/AIDS programme response, thereby reducing new infections by 50 percent[10].

As a comprehensive strategy to reach out to migrants, the programme proposes interventions at the source of origin, transit and destination points. At destination points, there are migrant interventions implemented through NGO-led targeted interventions. However, a large number of migrants are linked with various industries in the organized and unorganized sectors, as contract or informal workforce.

The programme envisages reaching migrant informal workforce, linked with industries through ELM, by integrating HIV/AIDS prevention into care programmes within existing systems and structures of industries.

Employer-led initiatives provide an opportunity to enhance the access of informal workforce to HIV prevention, care and support programme in India, thereby reducing their risk and limiting the spread of HIV/AIDS.

1.4 New opportunities: CSR as per Companies Act 2013

In India, the concept of Corporate Social Responsibility (CSR) has changed significantly over the last few years. While the philanthropic model is still largely popular, an emerging trend indicates a shift towards companies that are trying to establish a business model in all their sustainable development projects.

As per Section 135 of the Companies Act 2013, companies having net worth of Rs. 500 crore or more, or a turnover of Rs. 1,000 crore or more, or a net profit of Rs. 5 crore or more during any financial year are required to mandatorily spend 2 percent of its average net profit towards specified CSR activities. Such companies should constitute the CSR committee comprising of three or more directors with at lest one independent director. As per schedule VII of the CSR provisions, The activities related to combating HIV/AIDS are one of the key suggested activities that may be included and reported in CSR

With inclusion of 'Combat against HIV and AIDS' as an activity within the CSR rules of the Companies Act, the environment is most enabling for the launch of the 'Employer Led Model'

[8] ICTC Data from Thane District
[9] NACO, HIV Sentinel Surveillance, 2010
[10] NACO, HIV Sentinel Surveillance, 2010
[11] Policy Strategy and operational plan, HIV intervention migrants NACO 2010

Industry and HIV/AIDS

2
SECTION

2.1 Reasons for Industries to Respond to HIV/AIDS

For a business to be productive, offer services efficiently and turn a profit, skills and experiences of employees at all levels (senior managers to shop-floor workers) are needed for developing quality products or services which can be purchased by customers.

Instances from several industries globally have shown that HIV infection can disrupt the smooth operations of a business in a variety of ways. The argument that there is a vast pool of unemployed people who are promptly ready to replace existing employees must be qualified by reality: a particular business environment shapes skills and expertise that can take months to replace. The past experience of some industries in the world has shown that HIV/AIDS cuts into planned company expenses by increasing costs of employee health care, recruitment and training.

Instances from several industries globally have shown that HIV infection can disrupt the smooth operations of a business in a variety of ways. The argument that there is a vast pool of unemployed people who are promptly ready to replace existing employees must be qualified by reality

Studies reveal that workplaces in seriously affected countries report increase in labour turnover, cost of recruitment, training and staff welfare due to HIV/AIDS:

- A survey of 1006 firms in South Africa found that 43 percent of firms envisaged significant adverse impact within five years because of HIV/AIDS. Thirty percent of them reported higher labour turnover, and 24 percent recorded increased costs of recruitment and training[11]
- A six-firm study by Rosen and co-authors, in Botswana and South Africa, found that HIV/AIDS would impose costs ranging from 0.4 to 5.9 percent of the annual wage bill, in the next 10years. All six companies would have achieved positive returns on investment had they provided free antiretroviral treatment (ARV) to infected employees[12]
- A 14-firm study in Benin found that half of those employees identified as HIV positive held important positions[13]

Even with limited data, there is evidence of rising costs due to HIV/AIDS in Indian companies[14]:

- The Singareni Collieries Company Limited, Andhra Pradesh (high HIV-prevalence state), incurred an amount of INR 65 lakhs (US$ 144,444) in offering compensation to 29 employees, declared unfit to work by the company medical board due to HIV/AIDS-related illnesses (ILO study, 2005)
- The Employees State Insurance Corporation scheme spent INR 12.22 lakhs (US $ 27,155) in providing ARV treatment to around 200 ESIC beneficiaries in the year 2003-2004
- Indian Railways and BEST (Brihanmumbai Electric Supply and Transport Undertaking Ltd.), are spending substantial amounts of money in providing ARV treatment to their employees. Both have developed a comprehensive response to HIV/AIDS

[11] South Africa Business Coalition on AIDS 2004;The impact of HIV/AIDS on Business in South Africa
[12] Rosen et al. (2003); ibid
[13] Bollinger, Stover and Martin-Correa (1999); The economic impact of HIV/AIDS in Benin. The Policy Project. Futures Group International, September
[14] Working paper on Enhancing business response to HIV in India, ILO 2005

2.2 Industry Response to HIV/AIDS

In India there have been examples of initiatives by industries in the organized and unorganized sectors, as well as, industry associations such as CII, FICCI, and ASSOCHAM, in complementing the national programme through provision of HIV, STI prevention, care and treatment services to work forces.

A striking example of an industry with a large volume of informal workers, which has responded to HIV/AIDS, is Tata Tea. After the first HIV/AIDS case was detected in its South Indian tea plantation district in December 1996, the company expanded its health care services to include training, education and counselling on HIV/AIDS and STI. Punj Lloyd, Ambuja Cements, Apollo Tyres, ACC Cements Ltd, Vizag Steel, Larson and Toubro Limited, Reliance Industries, Shahi Exports, Ugar Sugars are more examples of industries in India who have reached out to formal and informal workforce with HIV/AIDS-prevention programme.

Despite positive examples like these, overall the private sector's response to HIV/AIDS in India requires further scaling up to ensure sustained impact.

Case studies of industry response to HIV/AIDS are enumerated in Annexure 1.

2.3 Benefits of Business Action against HIV/AIDS:

Many studies globally has shown that the return on investment in the prevention of HIV far exceeds that of standard capital investments. Studies have indicated that these returns, in terms of cost savings through preventing HIV, are as much as 3.5 to 7.5 times the cost of intervention[15].

Some of the intangible benefits for industries

- The stakeholder of industries are at risk for HIV/AIDS and it is business sense to invest in prevention activities to safeguard the key stakeholders e.g Tyre Companies investing in HIV/AIDS prevention activities for Truckers
- Employee satisfaction is seen more in industries which implement the health and prevention activities to safeguard the health of workers at all levels
- The training of employee and voluntarism for social cause at some of the industry level has helped to build the leadership and communication capabilities among the workers
- The New Companies Bill which was approved by Government of India, has made it mandatory for profit making companies to spend on activities related to Corporate Social Responsibility (CSR). The activities related to combating HIV/AIDS are one of the key suggested activities that may be included and reported in CSR [16]

Contribution to National and Millennium development goals;

- The investment in HIV/AIDS interventions also goes a long way as contribution to the National goal of reversing and halting the epidemic in India.
- By way of responding to HIV and AIDS, the enterprises can contribute to the Millennium development goal, as HIV and AIDS is one of the key issues to be address as part of Millennium development goal.

[15] Working paper on Enhancing business response to HIV in India, ILO 2005
[16] Activities which may be included by companies in their CSR, Section 135 Schedule VII of the Companies Act 2013

Need to Address Following Issues in Industry Response to HIV/AIDS

- **Interventions based on evidence and prioritization of industries:** Very few interventions in the past were based on evidence and prioritization of industries for HIV/AIDS intervention
- **Limited reach of workplace initiatives:** Most workplace initiatives in the organized sector reach only formal workforce of companies. Very few companies have gone beyond formal workforce to reach contract workers and supply-chain workers
- **Value addition to services:** There is need to go beyond awareness building and focus on increasing access and utilization of services such as ICTC, STI services and care and support
- **Recognising need for scaling up services:** There is need to integrate HIV/AIDS programmes within existing structures in organized and unorganized private sectors for ensuring long-term sustainability
- **Limited efforts to measure results:** Very few industry initiatives focus on measuring results and data, often not reported in the national programme

Benefits of direct business action against HIV/AIDS : Views of Industry Leaders

- *"Our companies are not in existence just to run our business and to make profits. We are responsible and good corporate citizen over and above our normal operations"*

  (Mr.Ratan Tata, Chairman Tata Group)

- *"A healthy workforce is the biggest asset for a company....A healthy workforce means less absenteeism that translates into more production, which could be ascribed to the success of the programme"*

  (Mr.Madhur Bajaj, Bajaj Auto Ltd. Pune)

- *"HIV records do not give the true picture, prevention is better for any company"*

  (Mr.Vijayakumar, Tata Tea, Munnar)

- "By contributing towards the cause of HIV prevention and control, especially at the workplace, the company enhances the quality of life of its employees, and they in turn, can ensure higher productivity for the organization"

  (Mr.N.Y.Sanglikar, Glaxo Smith Kline, India

Source : Enterprises and HIV/AIDS in India, ILO

Industry Structures and Definitions

SECTION 3

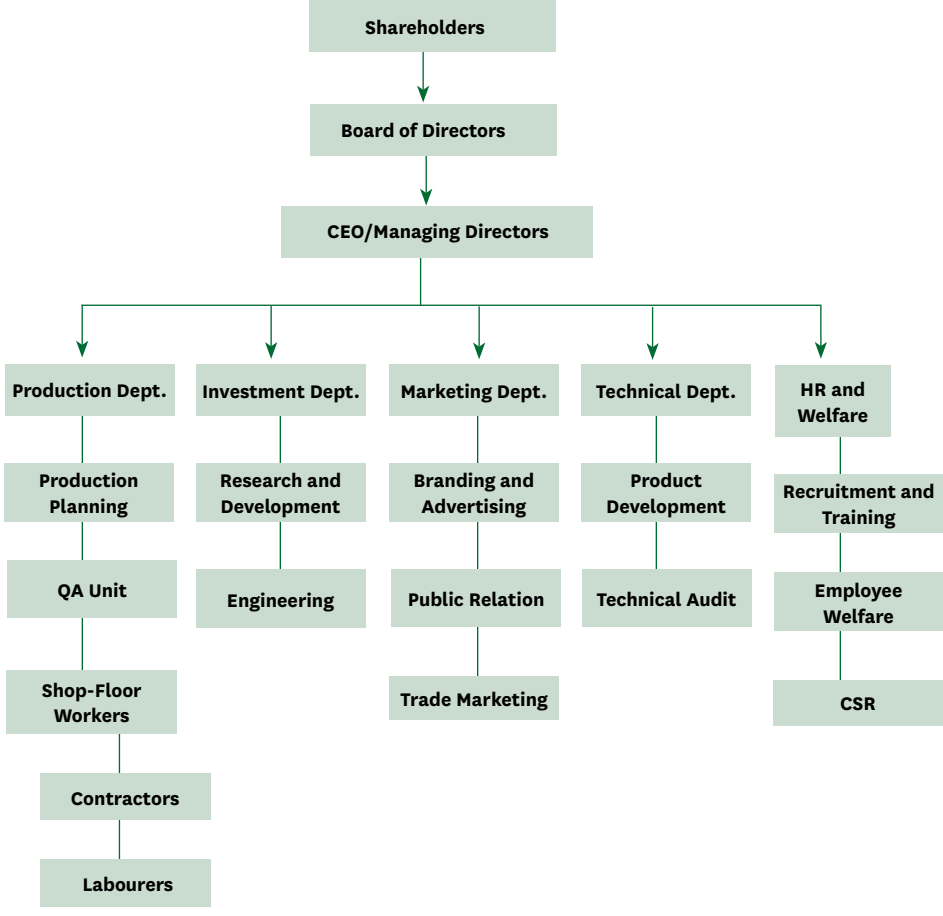
3.1 Definitions and Structure of Industries

This section explains the industrial landscape, structures and terminology on industry structure which will help in the following ways:

- To identify gatekeepers at industry level and approach them for facilitating ELM
- To understand key stakeholders at industry level
- To identify facilitators that can be leveraged at industry level for ELM
- To understand systems and structures that can be leveraged for facilitating ELM

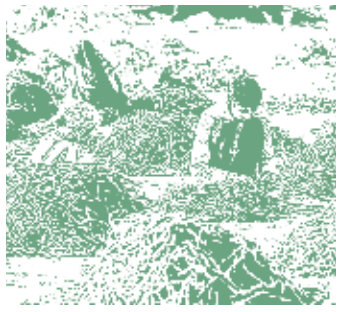
Definition of Organized Sector

The organized sector, also known as formal sector, consists of non-agricultural establishments in the private sector that have 10 workers or more and all establishments, irrespective of size, in the public sector[17]. A number of manufacturing establishments, transport, storage and communication enterprises, hospitality, community, social and personal services, among others, form the formal sector.



[17] Directorate General of Employment & Training, 2013

A formal workforce has the legal status and enjoys social protection and welfare facilities which may include paid leave, ESI, provident fund, pension, gratuity, maternity and health benefits, etc. Many formal sector establishments also employ informal workforce who do not generally receive any of the above privileges. The management structure of establishments/ enterprises in the organized sector varies across establishments. Given above is an example of the management structure of a private automobile company.



The board of directors, CEO or managing director are decision makers who need to be influenced for initiating interventions. Labourers are the target group and the rest could be facilitators.

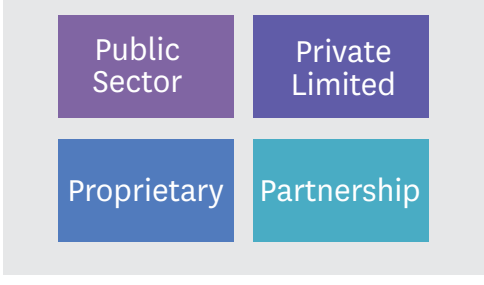
Definition of Informal workers: The National Commission for Enterprises in the unorganized sector defines informal workers or unorganized workers thus: "Unorganized workers consist of those working in unorganized enterprises or households, excluding regular workers with social security benefits and workers in the formal sector without any employment/social security benefits provided by employers" (NCEUIS, 2007).

Key Actors

The board of directors, CEO or managing director are decision makers who need to be influenced for initiating interventions. Labourers are the target group and the rest could be facilitators. Among facilitators, the CSR, HR, welfare departments and contractors, have crucial roles to play as structures that can influence the target group.

Major Types of Enterprises in Organized Sector

Given below are descriptions of major types of enterprises as defined by National Sample Survey Organization (NSSO, 2012). These may not be mutually exclusive.



Government/Public Sector Enterprise

An enterprise, which is wholly owned/ run/managed by central or state governments, quasi-government institutions, local bodies such as universities, education boards, municipalities, etc. The approach to public sector enterprises would be facilitated by concerned ministries at the national level. There are state-level public sector enterprises which can be approached through concerned state ministries.

Private Limited Company

This is a company which by its articles:

- Restricts the right to transfer its shares, if any
- Limits the number of its members to 50 not including-
  a) Individuals who are in the employment of the company, and
  b) Individuals who formerly in the employment of the company were members of the company and have continued to be members even after their employment terminated
- Prohibits any initiation to the public to subscribe for shares in/debentures of the company

Proprietary: When an individual is the sole owner of an enterprise, it is a proprietary enterprise.

Partnership: There may be two or more owners, belonging to the same or different households, on a partnership basis, with or without formal registration.

Unorganized Sector

The unorganized sector, also known as informal sector, consists of all unincorporated private enterprises owned by individuals or households engaged in the sale and production of goods and services, operated on a proprietary or partnership basis, and with less than a total of 10 workers (NCEUS, 2009).

According to the National Statistical Commission (NSC), the unorganized or informal sector constitutes a pivotal part of the Indian economy. The commission notes that more than 90 percent of workforce and about 50 percent of the national product are accounted for by the informal economy (NSC, 2012).

It may be noted that informal work is not just limited to informal sector but cuts across formal and informal sectors. Economic Review (2012-13) cites Kolli and Sinharay (2011), observing that a third of public and private sector jobs in India are informal.

A large number of construction workers, sugarcane harvesters, plantation workers, mine and quarry workers, fishermen, transport workers, etc. are informally employed.

An example of the chilli sector in Guntur is provided as an illustration of the structures involved in the informal sector. Structures vary from sector to sector.

Key Stakeholders and Structures in Chilli Sector, Guntur, Andhra Pradesh

Chilli is a seasonal crop in India and Andhra Pradesh (AP) is the largest producer of chilli in the country. Guntur district in APaccounts for almost one-third of chilli production in India. The chilli sector is completely unorganized. Labour contractors are the suppliers of the various *mandals*, thus, increasing inflow of migrants from these places. The duration of their stay is limited to availability of work. There are about 15,000 migrant workers in Guntur market yard itself. The estimated figure for workers in the chilli fields is about 40,000 and 5,000 workers across 80 cold storages in and around the Guntur market yard. There are no sector-specific associations for informal workers in the farm or market. However there are bodies such as Hamali Workers Union and Weighing Machine Workers Associations. The Hamali Workers Union is affiliated to AITUC.

Structures of oil, petroleum, construction, transport and plantation sectors are included in Annexure 2.

Key Stakeholders and Employers in Unorganized Sector

Within the unorganized sector, stakeholders will differ as per the nature of industry. For the purpose of ELM, it is envisaged to leverage existing systems and structures of industry to ensure sustainability. Hence in the context of the unorganized sector, the employer could be the key stakeholder from where systems and structures will be leveraged, such as industry associations, federations, societies, cooperatives, contractor/subcontractor systems and owners of unorganized sector units.

Introduction to Employer Led Model

4

SECTION

4.1 Meaning of ELM

The Fourth Phase of National AIDS Control Programme (NACP IV) proposes the Employer Led Model to enhance coverage of vulnerable informal workers linked with Industries using existing structures and systems of the industries. These are HIV interventions subsumed within the existing services provided by the employer benefitting both formal and informal workers of the industry. These are fully funded and managed by the employer whereas the technical and quality assurance support is provided by the National Program.

Goal

To help prospective employers implement a comprehensive program on HIV/AIDS prevention and care, by integrating awareness, service delivery with existing systems, structures and resources, within their business agenda.

Goal is to help prospective employers implement a comprehensive program on HIV/AIDS prevention and care, by integrating awareness, service delivery with existing systems, structures and resources, within their business agenda.

Objectives

- Increase awareness and access to HIV/AIDS prevention, care services for informal workers
- To create an enabling environment, by reducing stigma and discrimination, against people living with HIV/AIDS (PLHIV)
- To encourage and help prospective employers integrate and sustain the HIV/AIDS intervention programme within existing systems and structures

4.2 Key Strategies of ELM

To accomplish the above-stated objectives, ELMs will be implemented in organized and unorganized sectors using multi-pronged strategies, based on the following key principles:

- **Evidence-based prioritization of vulnerable industries for intervention:** For judicious use of resources, it is important to prioritize industries based on risk and vulnerability of informal workers, as not all migrant workers are at the same level of HIV risk
- **Focus on reaching informal workers in identified organized and unorganized sectors**
- **Increase awareness and access of condoms and HIV/AIDS/ sexually transmitted infections (STI) and tuberculosis (TB) prevention and care services:** The intervention will focus on creating awareness for condoms and increasing access to condoms by linking up with social marketing organizations (SMO). Similarly, focus will be on creating awareness and increasing access of services by integrating HIV/AIDS/STI services
- **Leveraging existing structures and resources from industrial sectors for implementation:** Existing systems and structures would be identified from each industrial sector and HIV/AIDS intervention will be integrated within systems and structure for sustainability and cost-effective interventions

- **Monitoring and Evaluation:** Monitoring and evaluation systems will be developed to ensure that activities will be measured at process, output and outcome level

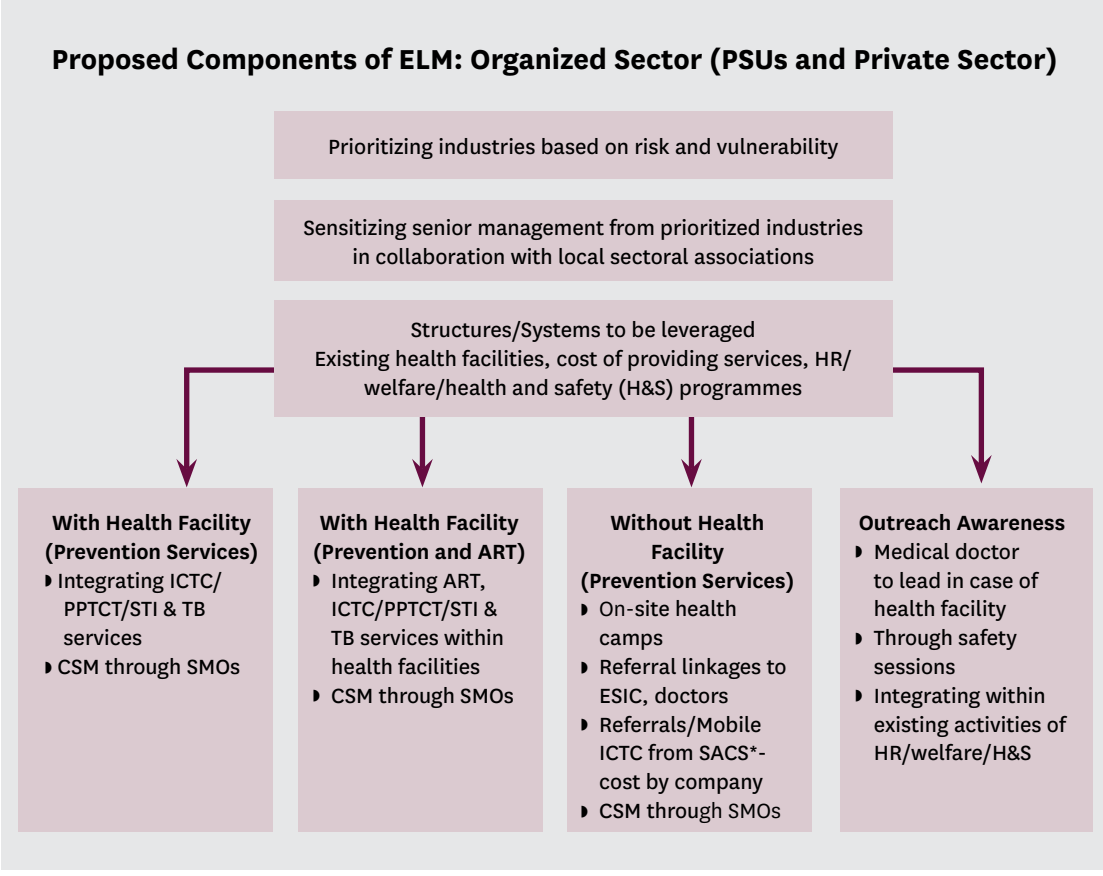
4.3 Potential Industrial Sectors for ELM

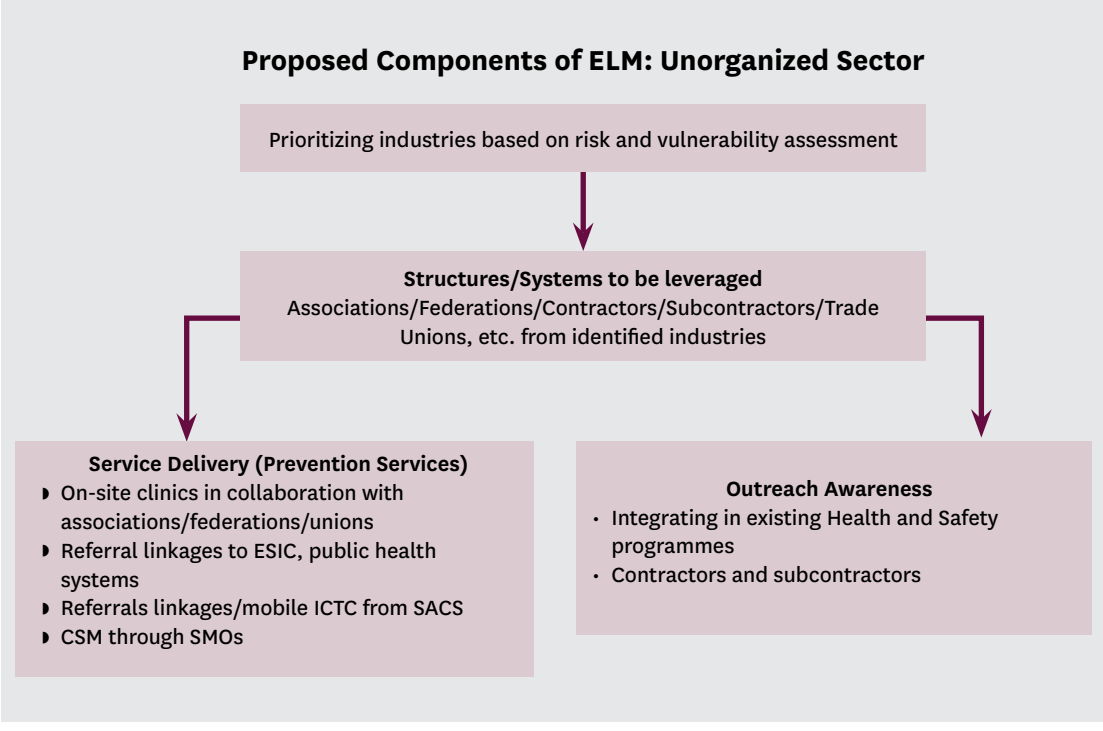
Industries (With large informal workforce)

<table>
<tr><td colspan="2">Organised Sector
(The organized sector, also known as formal sector, consists of non-agricultural establishments in the private sector that have 10 workers or more and all establishments, irrespective of size, in the public sector (DGET, 2013))</td><td colspan="2">Unorganized Sector
(All unincorporated private enterprises owned by individual or household engaged in sales and production of goods and services, operated on a proprietary or partnership and with less than 10 workers (NCEUS,2008)</td></tr>
<tr><td>Public Sector Units (PSU)</td><td>Private Sector Industries</td><td>Unorganized Industries</td><td>Small-Scale Industries (SSI)</td></tr>
<tr><td>Employer in PSU
• Central or state ministries associated with PSUs
• Senior management in PSU</td><td>Employer in Private Sector Industry
• Board of directors
• Senior management of Company</td><td>Employer in Unorganized Industry
• Contractors/ subcontractors
• Industry association
• Federations
• Societies
• Cooperatives</td><td>Employer in SSI
• SSI Association
• Owners of unorganized sector units</td></tr>
<tr><td colspan="2">Examples:
• Cement
• Automobile
• Steel
• Textile
• Paper industries
• Oil and petroleum
• Fertilizer manufacturing
• Power plants
• Tourism and hospitality
• Transport sector
• Mining</td><td colspan="2">Examples:
• Construction
• Seasonal harvesting
• Tea plantation
• Quarry workers
• SSI
• Fishing
• Leather and tannery
• Hotel industry</td></tr>
</table>

4.4 Components of ELM

The following flowchart explains various components of ELM in organized industrial sectors.

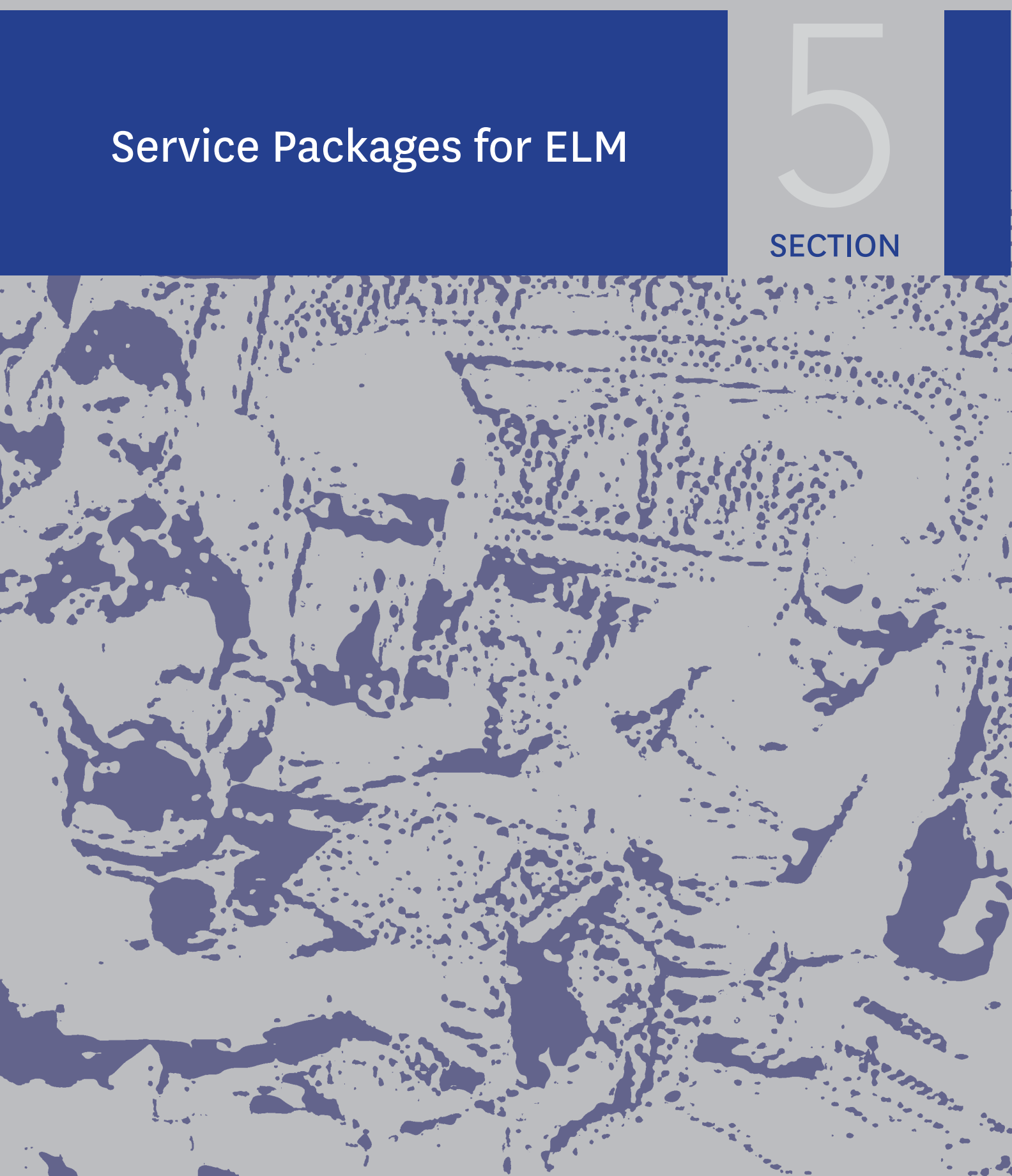




Service Packages for ELM

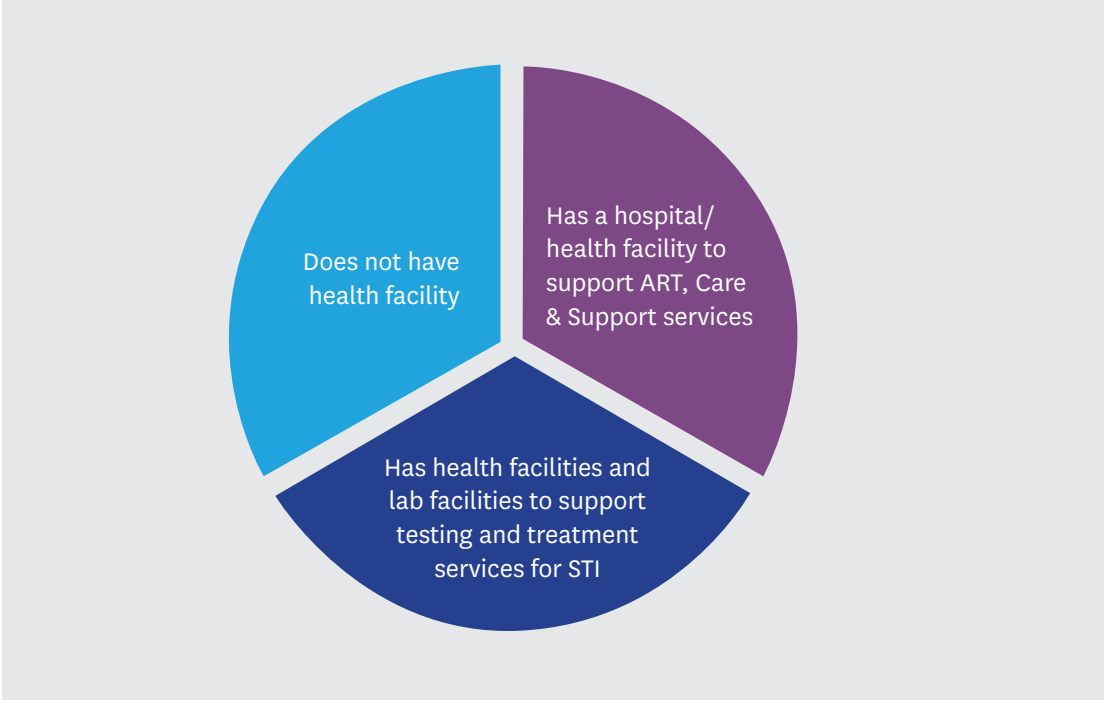
5

SECTION



This section explains various service packages that can be implemented by the industry. SACS may present the service packages to employers on the basis of systems and structures available in the industry. Employers can also decide which service package to implement on the basis of cost, systems and structures available at industry level.

5.1 Organized Sector (PSUs and Private Sector Industries)



Industries are broadly divided into three categories for suitable service packages.

I] Prevention Package:

- **Outreach Awareness**

  a. **Outreach activities:** Medical and paramedical staff, supervisors, contractors and employee volunteers would be trained for conducting outreach activities in one-to-group sessions. Trained staff at industry level will conduct these sessions with informal workers to create awareness on HIV/AIDS during their routine interactions.

  Outreach awareness sessions may be integrated within regular health and safety programmes, HR trainings, welfare activities to be built in continuity and sustainability of awareness activities.

  b. **Mid media campaigns:** Mid media techniques will be used to create interest and generate awareness among large numbers. Employee volunteers from the industry can also take initiatives to conduct mid media activities on a regular basis to reach informal workers. Industries are expected to contribute time of employee volunteers and resources for organizing mid media activities on a regular basis.

  c. **Development of IEC/BCC Materials:** Standard prototypes for IEC and BCC materials will be made available to industries through SACS/TSU. The IEC/BCC material may be

printed by industries as per prototypes provided by SACS, according to the needs of the community and the migrant informal workers.

d. SACS will also facilitate provision of a prototype of resource kits containing the following items for informal workers through employers. SACS will support the development of state-specific resource kits. Condom packs may be provided with the kit by the industry.

- Information on HIV/AIDS/STI
- Details of integrated counselling and testing centre (ICTC)/ART centre at destinations and source states
- Information on central and state-level social welfare schemes for migrants

Condom Programme: SACS will facilitate linkages with social marketing organisations/internal work force for condom social marketing programme to establish condom outlets in and around the industries and condom vending machines (CVMs) within industries. SACS will facilitate the availability of free condoms at clinics, health setups and with nodal officers within industries for increasing accessibility.

Prevention Health Services: If industries have staff and facilities, STI, ICTC and prevention of parent to child transmission (PPTCT) services will be integrated within existing hospital and health setups in industries. If the industries lack health facilities, referral linkages will be developed with existing services within the public health system and mobile services provided by SACS.

a. **STI treatment and management:** STI treatment service will be integrated within the existing health setup available at the industry. Medical and paramedical staff will be trained in providing syndromic management of STI as per DAC guidelines.

   SACS will provide specifications for STI drugs and test kits as per DAC guidelines and will facilitate industry for procurement of test kits as per DAC quality assurance guidelines.

b. **Health camps:** If the industry does not have a health facility, an allopathic (MBBS) doctor can be hired for conducting health camps on regular basis at industry sites. Health camps will include general health checkups, syndromic management of STI, care and treatment of RTI as per Department of AIDS Control's (DAC) STI management guidelines. This will be used as an opportunity to provide information on HIV/AIDS and STIs.

c. **Linkages with private empanelled doctors by company/ESIC facilities:** The management will be sensitized and motivated to provide free treatment services for informal workers through empanelled private hospitals or through referrals to health care facilities available with ESIC.

d. **Referral system:** In case the industry lacks a health facility or there is a nearby public health system which is accessible to informal workers, the referral system may be strengthened through introduction of a health card system. Using this, individual informal workers referred from industry sites will be tracked and reported back for records to the industry nodal officer.

e. **ICTC/PPTCT services:** If the industry has health facilities, ICTC and PPTCT services will be integrated within the existing health setup. The medical and paramedical staff at the health setup will be trained in counselling and conducting HIV testing using rapid test

kits. SACS will provide specifications for HIV test kits as per DAC guidelines and facilitate procurement of test kits for the industry according to DAC quality assurance guidelines.

If the industry does not have a health facility, SACS will facilitate referral linkages with mobile ICTC services or ICTC services within the public health system. Referral tracking systems will be established for tracking of informal workers from industries.

II] Treatment and Care Package

- **ART services integrated with company hospital:** If the industry has its own hospital setup, management will be sensitized and motivated to provide free treatment services for PLHIV through the company hospital. Industries, which wish to integrate ART services, ART care support services, will be established as per DAC guidelines for PPP-ART
- **Referral linkages for care and treatment services:** In case the industry does not have adequate infrastructure as per DAC guidelines, referral linkages will be established with near by government ART centres or Link ART centres
- **Psycho-social support services:** Linkages will be established with PLHIV networks so that infected informal workers will be linked to various service components through the network. Through this linkage, peer counselling support, group therapy, capacity building and financial support for livelihood options, etc. will be made more accessible

If the industry does not have a health facility, SACS will facilitate referral linkages with mobile ICTC services or ICTC services within the public health system. Referral tracking systems will be established for tracking of informal workers from industries.

III] Developing Enabling Environment

- **Facilitating HIV policy in industry:** SACS will facilitate linkages of industries which wish to adapt the HIV/AIDS policy to the Department of Labour and Employment, mandated for implementing the National HIV/AIDS Policy inindustries
- **Social welfare and social security:** SACS can facilitate linkages with various agencies working on social welfare and social security measures for informal workers; work towards improving the knowledge of informal workers on various existing schemes; facilitate easy access to various welfare programmes as well as social protection activities of the government

5.2 Packages for Unorganized Sector including Small Scale Industries

Employers in the context of unorganized sector: Within the unorganized sector, employers and stakeholders will differ, depending on the nature of the industry. For the purpose of ELM, it is envisaged to leverage existing systems and structures of industry to ensure sustainability. Hence in the context of the unorganized sector, the employer will be the key stakeholder from where the systems and structures will be leveraged. For instance, industry associations, federations, societies, cooperatives, contractor/subcontractor systems and owners of unorganized sector units.

- The unorganized sector and SSIs form the supply chain of many large and big industries. Support can be leveraged from these large and big industries for conducting HIV/AIDS activities as part of their CSR activities

E.g. Small-scale textile/garment industries form the supply chain of large textile and garment companies such as Levi Strauss & Co. These companies have CSR policies for supporting workers in the supply chain, which can be tapped for leveraging resources for health and HIV/AIDS programme activities for supply-chain industries

- Organized industries, which employ supply chain from the unorganized industry sector, can make it mandatory for contractors and owners of SSIs to implement HIV/AIDS programme activities as part of the contract obligation

E.g. The Ballarpur Industries Ltd. (BILT) has made it mandatory for vendors and supply chain working on its contract, to implement HIV/AIDS programme activities for their workers

Organized industries, which employ supply chain from the unorganized industry sector, can make it mandatory for contractors and owners of SSIs to implement HIV/AIDS programme activities as part of the contract obligation

Services Package for Unorganized Sector and SSIs

I] Outreach Awareness

- **Outreach activities:** Supervisors, contractors, subcontractors and volunteers from industry would be trained for conducting outreach activities in one-to-group sessions with informal workers. Awareness activities will also be regularised through advocacy with associations, federations and societies of informal workers

- **Mid media campaigns:** SACS-led mid media activities will be used to create interest and generate awareness among the informal workforce. Employee volunteers among informal workers can also be trained for conducting small activities of entertainment involving HIV/AIDS/STI among themselves

- **Development of IEC/BCC Materials:** SACS can facilitate IEC material for informal workers in the unorganized sector. Effort can be made to leverage support from owners, associations, federations and societies of the unorganized sector. The unorganized sector forms the supply chain of many large and big industries and additional support can be leveraged from these industries for conducting HIV/AIDS activities

- **Condom Programme:** SACS will facilitate linkages with the Social Marketing Organisations for Condom Social Marketing Programme (CSMP) to establish condom outlets in and around industries. SACS will facilitate the availability of free condoms at clinics, health set-ups and with nodal officers within industries for easy accessibility

II] Prevention Health Services

- **Health camps:** An allopathic (MBBS) medical doctor, can be hired for conducting health camps on regular basis in an around work sites. Health camps will include general health, syndromic management of STI, care and treatment of RTI as per DAC guidelines. It will be used as an opportunity to provide information on HIV/AIDS and STIs. Effort can be made

to leverage resources from associations/federations/societies/builders/contractors for conducting these camps

- **Referral system:** The referral system will be strengthened through the introduction of a health card system. Using this, individual informal workers, referred from these sites, will be tracked and reported.
- **ICTC/PPTCT services:** SACS will facilitate referral linkages with mobile ICTC services or ICTC services within the public health system. A referral tracking system will be established for referral tracking from the industries

III] Treatment and Care Package

- **Referral linkages for care and treatment services:** Referral linkages will be established with government ART centres, PPTCT clinics and ICTC. Linkages also will be made with PLHIV networks so that infected informal workers are linked to various service components through the network. Through this linkage, peer counselling support, group therapy, capacity building and financial support for livelihood options, etc. will be made more accessible.

5.3 Building Enabling Environment

- **Facilitating HIV policy in industry:** In the unorganized sector, the following stakeholders can adopt the HIV/AIDS policy:
  - SSI associations
  - Sector-specific federations, societies and cooperatives in unorganized sector
  - Contractors
  - Sector-specific employer associations like builders' associations
  - Informal workers' union e.g. 'Mathadi Workers Union', Nirman Majdur Sangh in construction sector

SACS will facilitate linkages of industries to Department of Labour and Employment, mandated for implementing National HIV/AIDS Policy at industry/work place level.

- Social welfare and social security: SACS can facilitate linkages with various agencies working on social welfare and social security measures for informal workers; work towards improving the knowledge of informal workers on various existing schemes; facilitate easy access to various welfare programmes as well social protection activities of the government

Detailed framework of type of industry, key components and structures/systems that can be leveraged is presented in Annexure 8.

5.4 Approximate Cost of ELM Packages

The approximate cost for different packages propropsed under ELM are presented in the table below the industries can select the preferred package from the available options in the following table.

Services	Number of beneficiaries per year	Total cost per year	Unit cost per person per year
Only Outreach Sessions	500	INR 45,000	INR 90
Outreach + STI management	500 (30 STI cases+500)	INR 121,000	INR 228
Only STI management	500 (30 STI cases+500 General health	INR 81,000	INR 152
Only outreach Sessions	1000	INR 80,000	INR 80
Outreach + STI management	1000 (60 STI cases+1000)	INR 194,000	INR 183
Only STI Management	1000 (60 STI cases+1000 general health)	INR 114,000	INR 114
Only outreach sessions	3000	INR 230,000	INR 77
Outreach + STI management	3300 (300 STI cases+3000 others)	INR 410,000	INR 124
STI management	300 cases	INR 180,000	INR 600
STI + OI management	400 (300 STI cases + 100 PLHA)	INR 580,000	INR 1450
STI management plus HIV and RPR testing	1300 (300 STI cases + 1000 others)	INR 6.1 lakhs	INR 469
HIV testing	1000	INR 1.17 lakhs	INR 117
Only ART Services	100	INR 26.4 lakhs	INR 26,400
ART plus OI management `	100	INR 30.4 lakhs	INR 30,400
ART plus CD 4 testing outsourced	100	INR 27.4 lakhs	INR 27,400

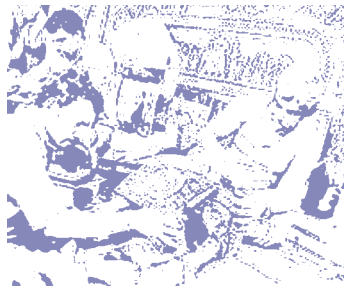
Approximate Cost of pakages and Services is given in Annexure 3

Benefits of Direct Business Action against HIV/AIDS

Investment returns in HIV/AIDSprevention far exceed that of standard capital investments. Studies have indicated that these returns, in terms of cost savings through preventing HIV, are as much as 3.5 to 7.5 times the cost of intervention[18].

[18] Source: ILO guidelines for employers

5.5 Expectations of Employers in Organized and Unorganized Sector



Industry with health facilities

- Integrating STI Management within existing health setups
- Integrating ICTC/PPTCT services within existing health setups
- Integrating ART and care and treatment services wherever possible
- Share infrastructure, time of medical, paramedical staff, lab services
- Contribute resources for drugs, commodities such as test kits, consumables
- Outreach services through medical, health and safety, employee volunteers
- Contribute resources for printing of IEC material

Industry without health facility

- Contribute resources for organizing health camps for STI Management and general health services
- Contribute resources for drugs, test kits and other commodities
- Linkages with mobile/facility-based government ICTC
- Linkages with ART and care & treatment facilities, IEC services through medical, H&S, employee volunteers

Resources for the ELM

Employers, associations, federations and individual unit owners are expected to contribute resources for ELM to reach informal workers and supply chain, as part of their CSR contribution. Schedule VII of the Company Bill for CSR includes HIV/AIDS as one of the 10 areas that industries can consider for CSR activities. This is an opportunity to mobilize industries as resources invested through ELM for informal workers and supply chain can be showcased under CSR activities. This will be an added advantage for large industries which can report activities under ELM as part of sustainability reporting.

Employers, associations, federations and individual unit owners are expected to contribute resources for ELM to reach informal workers and supply chain, as part of their CSR contribution. Schedule VII of the Company Bill for CSR includes HIV/AIDS as one of the 10 areas that industries can consider for CSR activities.

Prioritizing Industries for Employer-Led Interventions

SECTION 6

6.1 Introduction

Evidence suggests that certain work forces may have heightened vulnerability compared to certain others, given the same geography. Hence it is important to map and prioritize the work forces for better results and planning interventions appropriate to a specific geographical area. These can be migrant interventions only, ELMs only or a hybrid model in a specific geographical area. A study by Shiva Halli and Others[19] in Karnataka found that workers from some economic sectors had higher risk of HIV infection than others. It recommends that given the resource constraints, priority for interventions should be given in addressing work forces from prioritized sectors. Another study by Population Council revealed that contracted labourers were more likely to report HIV-risk behaviours than non-contracted labourers. Now, how we prioritize is an important step to be addressed at the state level.

Mapping and Prioritizing Informal Workers

Since the focus is to initiate employer-led interventions at the workplace in a given state, we should look for large clusters of informal sector work forces (may be part of PSUs, private enterprises).

Evidence suggests that certain work forces may have heightened vulnerability compared to certain others, given the same geography. Hence it is important to map and prioritize the work forces for better results and planning interventions appropriate to a specific geographical area.

Steps to be Considered for Deciding Interventions (both TI and ELMs)

1) Collection of Secondary Data on Informal Workforce in Any Area

Source: Department of Labour and Employment, Department of Industries and Commerce, employers/industries associations, trade unions, contractors, employment agencies, mapping data available with SACS

Analysis of data would provide information regarding:

- Occupation sectors which employ large informal workforce
- Approximate size of workforce
- Kind of existing employment relationships
- Distribution of workforce in terms of geographical spread (such as dense clusters in case of industrial zones, textiles, etc. dispersed in a limited geographical area for construction, mining, etc. dispersed in a large geographical area for agriculture, etc.)

2) Mapping of Services

Source: Existing information with health department, industries, ESIC, secondary information from existing TIs in area

- Analysis of data would provide information regarding:
- Availability of services by providers (government, private, semi/non-qualified, industry-led health facilities, outreach health facilities by industries/non-governmental organizations (NGOs)/charitable institutions)

[19] Shiva S Halli and others (2009), Assessing HIV Risk in Workplaces for Prioritizing HIV Preventive Interventions in Karnataka State, India, Sexually Transmitted Diseases, 36(9), PP: 556-563

- Level of service access by informal workforce by providers, affordability, preferences
- Referral systems available (primary, secondary, tertiary)
- HIV-related services (testing, ART, STI/RTI treatment, condoms)

3) Understanding Risk Pattern

Source: Indirectly from existing HRG TIs in the area, STI data from clinics, data from ICTC and directly through FGD among informal workforce at residences/workplaces/hotspots of HRG TIs

Analysis of data would provide information regarding:

- Percentage of male clients of FSW/MSM that are migrants/informal workforce (through FGD with FSW/MSM, FGD with clients at hotspots, FGD among migrant/informal work force)
- Percentage of migrants/informal workforce to have reported to condom use during last sexual intercourse (considering records of existing TI, existing ICTC)
- Barriers to condom negotiation among clients representing migrants/informal workforce (from FGD with FSW/MSM)
- Pattern of STI prevalence among migrants/informal workforce (from OPD data of DSRCs, STI clinics, local paractioner)
- ICTC data on prevalence and behavioural pattern among migrants/informal workforce (from existing ICTC/FICTC records)
- FGD with migrants/informal workforce would indicate risk exposure pattern (average number of high-risk exposure, condom use, STI etc.

4) Understanding Vulnerability Pattern

Source: Directly through FGD among informal workforce at residences/workplaces/hotspots of HRG TIs

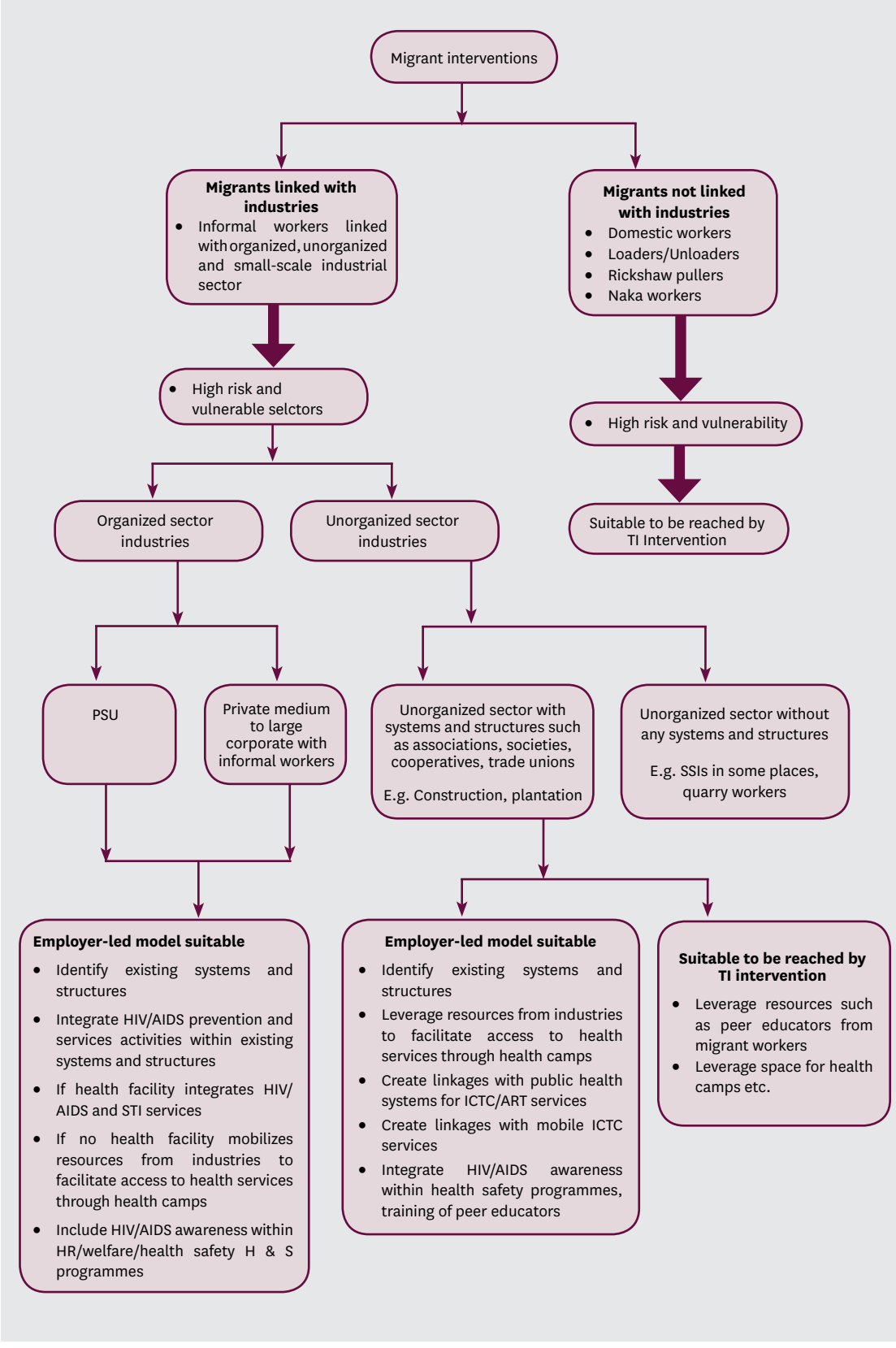
Analysis of data would provide information regarding:

- Myths and misconceptions, level of knowledge about HIV/AIDS
- Living conditions and other employment conditions which have bearing on substance use
- High-risk exposure

With these sets of information, SACS /TSU have to use the following algorithms to understand the volume of migration, employment conditions, risk and vulnerabilities -- to decide upon the need for having TI or ELM interventions in a specific geographical area. In case of hybrid models (coexistence of ELM and TIs in a specific geographical area) there are certain advantages which are:

- Scaling up of services through ELM which can further be linked to target population of TIs
- TIs can focus on difficult and unreached areas/unorganized sectors with limited or no structures or systems within employment relations

6.2 Flowchart with Algorithm to Identify and Decide whether Intervention will Require ELM Approach or TI Approach



Algorithm for ELM

6.3 Programme Feasibility Analysis

A review of feasibility of a programme needs to be done in order to devise strategies for engaging the industry advocating ELM. Whether the industry is profit-making or not, how scattered workforce is, availability of workforce (seasonal or continuous), the best time for engaging workforce --are some parameters to be considered.

6.4 Roles and Responsibilities

Role of SACS/TSU

- Collate data on industries
- Conduct rapid vulnerability assessment through key informants
- Analyse ICTC data for occupation
- Examine program feasibility
- Inventories systems and structures available at industry level, which can be leveraged for HIV/AIDS programme

Example of methodology for prioritizing industries for employer-led intervention is included in Annexure 4.

Roles and Responsibilities of Key Stakeholders in ELM

7

SECTION

7.1 Role of Employers

This chapter explains the roles and responsibilities of key stakeholders for facilitating employer led model. The roles are explained as per the stakeholders.

- **Overall facilitation, implementation & monitoring of HIV/AIDS programme activities**
  - Overall implementation and lead in intervention for HIV/AIDS
  - Contributing infrastructure, human resources and financial resources for implementation
  - Ensuring supply of drugs, test kits, consumables for implementing HIV/AIDS/STI services at industry level
  - Integrate and scale-up activities under the model through existing CSR initiatives
  - Identifying nodal person in industries for facilitation of implementation
  - Formation of coordination committee at industry level in collaboration with SACS
  - Overall monitoring of implementation through coordination committee
  - Sharing reports with SACS/DAPCU
- **HIV/AIDS awareness activities**
  - Integrate HIV and AIDS awareness activities within existing health and safety, welfare and human resources (HR) activities
  - Training of employee volunteers, supervisors, contractors in conducting one-to-one and one-to-group sessions on HIV/AIDS
  - Training of health staff to conduct one-to-group sessions in health settings
  - Printing of IEC material as per the prototypes provided by SACS
  - Ensuring availability of condoms and IEC at industry level
- **HIV/AIDS/STI services within industry with health facilities**
  - Provide treatment for STI /RTI as per national guidelines
  - Deliver ICTC/PPTCT services through fixed, mobile or outreach health facilities
  - Implement ART, care and treatment services
  - Ensure supply of drugs, test kits for implementation of services at industry level
- **HIV/AIDS/STI services within industry with no health facility**
  - Use existing/hire allopathic medical doctor to conduct on-site health camps for STI/RTI treatment at industry site
  - Develop access to health services by referral linkages with ESIC, public health systems or empanelled doctors
  - Establish linkages with mobile/facility-based government ICTC
  - Linkages with ART, care and treatment facilities
  - Contributing resources such as drugs, hired medical doctor for conducting health camps at industry level

7.2 Role of DAC

- Overall policy directions and guidelines for ELM
- Coordination with Ministry of Labour and Employment, NRHM and other ministries
- Signing of MOUs with ministries related to public sector units (PSUs) to facilitate scaling up of ELM in PSUs
- Facilitate advocacy and coordination with concerned ministries, employers' associations, trade unions
- Ongoing review and revision of policy, strategies and implementation plan
- Technical support and capacity building of SACS/TSU
- Provide prototypes for IEC material, advocacy tools for facilitating ELM implementation
- Facilitate engaging large industries with operations across the country through a national-level effort

7.3 Overall Role of SACS

- Responsible for facilitating roll out of the Employer Led Models at state level by identifying potential industries, engaging with industries to develop specific proposals and provide ongoing support to roll out
- Project Director of SACS has to oversee the implementation and review of ELM activities at SACS level.
- Role of different division in SACS would be as follows:

TI Division:

- Nodal division to identify potential industries in close coordination with TSU, Mainstreaming division and other partners such as industry associations etc.
- Engaging with industries and preparing action plan.
- Organising State level sensitisation meeting chaired by Project Director SACS.
- Facilitate rolling out condom social marketing by industries.
- Overall coordination with other divisions of SACS, NRHM and other stakeholders.
- Programme monitoring, mentoring industries, documentation and dissemination at state level
- Reporting to DAC on employer led activities
- Facilitate for implementation of HIV/AIDS/STI services at the industry level for increasing access of services for migrant workers
- Build capacities of PLHIV groups for active participation in the facilitation of Employer led model at State level
- Conduct periodic mentoring and support visits

SACS is Responsible for facilitating rollout of ELM at state level by identifying potential industries, engaging with industries to develop specific proposals and provide ongoing support to roll out

ICTC/STI/ART Division:

- Provide support in preparing Industry specific service delivery models and action plan.
- Include the training targets in the AAP and implement training of medical/paramedical staff at the industries.
- Provide support in establishing services and handholding for service delivery.
- Enccourage to participate in EQAS.
- Facilitate availability of mobile ICTC facility for ELM project intervention area.
- Facilitate linkages with drug and test kit manufacturers for procurement of drugs and kits as per the standard guidelines
- Facilitate training and capacity building of the medical, para medical staff for implementing HIV/AIDS/STI services

IEC and Mainstreaming Division:

- Provide wide publicity of the need for ELM in different messaging, forums.
- Provide IEC materials to industries during initial phase (first 3 months at least 2,000 per industry) and provide prototypes for printing by industries.
- Training of supervisors, contractors, volunteers on communication session on HIV and AIDS.
- Coordination with State Department of Labour and Employment, Department of Health Services and other relevant government departments for mobilizing industries
- Advocacy and coordination with state level employers organizations, trade unions, PLHIV network and other relevant stakeholders
- Facilitate training and capacity building of contractors, health staff, supervisors, employee volunteers for conducting awareness sessions with informal workers
- Facilitate the development of HIV/AIDS policy by developing linkages with industries and Ministry of Labour and Employment (MoLE) at State level

7.4 Role of TSU

- Provide support to SACS in developing implementation plan at industry level, rolling out activities, training of staff, coordination meetings at industry and SACS level for ELM activities
- Provide support in designing specific activities as per needs of industry/specific sector
- Develop capacity of TSU programme officers, SACS officers and DAPCU in facilitating rollout of ELM
- Conducting support and mentoring visits to industries in collaboration with SACS and DAPCU

7 .5 Role of DAPCU

- Support SACS/TSU in planning (identifying), implementation of the programme at district level or in a cluster of districts

- Follow up with industries/employers for engaging in ELM at district level
- Support SACS/TSU in facilitating advocacy meetings and making inroads into district-level industries for ELM
- Follow up and coordinate with district level stakeholders for facilitating ELM
- Support SACS/TSU for conducting trainings at industry level, service linkages with public health systems, coordination for mobile ICTC linkages and linkages with CSM

7.6 Role of National and State-Level Employers' Associations

- Extend support to SACS in conducting advocacy meetings with employers
- To be part of state-level coordination committee for ELM facilitated by SACS
- Facilitate support from member industries
- Support SACS in creating access to industries for ELM
- Facilitate support from state-level employers' associations
- Facilitate advocacy with member industries

7.7 Role of PLHIV groups

- Involvement of PLHIV in sensitization meetings at state level
- PLHIV group can provide specific inputs in activities that relate to building an enabling environment and steps for reducing stigma and discrimination at workplace

Detailed framework of proposed key activities, roles and responsibilities of each stakeholder is included in Annexure 4.

Institutional Arrangement and Management Structure

SECTION 8

This section explains the management, technical structure and institutional arrangements proposed at various levels to ensure smooth facilitation of ELM.

8.1 Institutional Arrangement between Employer and SACS at Field Level

The institutional arrangements are proposed to formalize the partnership between Employers and SACS at field level. The institutional arrangements will help to build ownership of the activities within the industry and SACS systems and structures.

- It is proposed that a letter of intent – as far as possible on official letterhead be taken from industries expressing interest in implementing ELM

Sample of letter of intent included in Annexure 5

- It is also proposed that after receiving letter of intent, a detailed proposal and action plan be developed with each industry. SACS/ TSU will facilitate developing proposal along with coordination committee at employer/industry level
- Proposal and action plan to be signed by SACS and employers. This will serve as a guide for implementation of ELM at industry level

Sample of proposal format is included in Annexure 5.1

- Coordination committee at industry level is proposed to have a representative from SACS/ TSU for better coordination

It is proposed that a letter of intent – as far as possible on official letterheads-- be taken from industries expressing interest in implementing ELM (sample of letter of intent included in Annexure 5)

8.2 Management and Technical Support Structure

Following management and technical support structure is proposed at national, state and industry levels for facilitation of ELM.

National Level	State Level	Industry Level
• DAC - TI division overall lead • TI division -coordinate with other DAC divisions and departments • Two PPP consultants for ELM (till 2017) • PIPPSE project – technical support for ELM (till 2017)	• SACS - TI division overall lead at state level • SACS-TI division coordinate with other SACS division • TSU to support SACS on ELM • Dedicated programme officer –for ELM and Migration related activities at TSU • DAPCU to lead at district level • Mainstreaming consultant/in-charge to support TI division	• Senior management overall lead • Nodal officer at industry level e.g. - Health facility in charge - CSR Head/Head HR • Coordination committee – representation from senior management, key departments, DAPCU/SACS/ TSU, industry association

8.3 Institutional Arrangements at Various Levels

Employer/Industry Level: Three arrangements are proposed at industry level

- **Senior Management Involvement—**To ensure ELM is successful, it is necessary that senior management of the company is involved in planning, implementation and monitoring of programme
- **Identify Nodal Person—**Identifying a nodal person who can champion the cause and take the initiative forward
- **Formation of Coordination Committee—**To be chaired by senior management, having at least three directors, one should be an indipendent director along with the stakeholders to oversee programme activities

Prospective Nodal Person:

- Key facilitators, such as senior management at organized industry, associations, societies, trade unions, at unorganized sector need to identify nodal person
- Nodal person will champion ELM at industry level and anchor its overall implementation in industry
- Nodal officer should have leadership skills and be self-motivated to drive these efforts

Suggested Nodal Officer at Industry Level

PSUs and organized sector	• Senior management • CSR incharge • HR head • Health and safety incharge • Medical doctor • Operations incharge • Welfare incharge
Unorganized sector	• Supervisor • Chief contractor • Secretary of society, federation, industry association • Representative from trade unions

Role of Nodal Person

- Provide overall support for ensuring implementation of ELM
- Coordinate between SACS and various departments for implementation of HIV/AIDS activities
- Coordinate and implement HIV/AIDS services
- Collect data from various services and compile reporting for SACS

Possible Members of Coordination Committee

Strategically it is useful to have important department heads of the company to be part of the coordination committee and chaired by the CEO or the MD. There could be around four to five members and key departments such as operations, human resource, welfare department, finance

department should be part of the coordination committee. The representatives from SACS/TI division/TSU/DAPCU, trade unions and industry association are strongly recommended to be part of the coordination committee.

Coordination Committee in Unorganized Sector

At unorganized sector sites, representatives from various stakeholders such as trade unions, contractors, federations, cooperatives, societies, associations, etc. need to be identified for forming the coordination committee. The list of stakeholders will vary across industries. The representatives from SACS/TSU/DAPCU should be part of the coordination committee to facilitate the overall process.

Role of Coordination Committee

- Coordinate with SACS for implementation of ELM
- Ensure support from other departments/stakeholders from industry for implementing ELM
- Approve and support plan of implementation
- Monitor process of implementation and ensure that it is carried out according to plan
- Monitor and supervise HIV/AIDS services implemented at industry level
- Spearhead process of adopting HIV/AIDS National policy in case industry wants to adopt the policy

Coordination Committee Meeting

It would be ideal if the coordination committee meets on a monthly basis and takes stock of the programme. But if it is not possible, at least a quarterly meeting should be organized. The process of the coordination committee meeting should be as follows:

It would be ideal if the coordination committee meets on a monthly basis and takes stock of the programme. But if it is not possible, at least a quarterly meeting should be organized.

- Finalize an agenda
- Send copies of agenda and monthly or quarterly report, a few days prior to meeting, to all participants
- Prepare presentation summarizing report and outlining future steps
- Agenda of meeting could involve presentation on key activities conducted, progress Vs plan, sharing successes, discussing challenges and finding out solutions
- Adapting HIV/AIDS policy in case the industry is willing to adapt policy
- Minutes of meeting should be prepared and shared with committee members

Experience has shown that formation of a coordination committee and continuous interaction with them through meetings helps in increasing the commitment of the senior management for the programme. Thus it is highly advisable to have a functional coordination committee in each company.

8.4 SACS Level

Nodal Person at SACS

- The joint director/deputy director/assistant director (JD/DD/AD) TI would be the nodal person. He/she would be supported by TSU or as designated by PD. He/she will be the point of contact for industries/employer at SACS
- Nodal person at SACS would closely work with other divisions of SACS (i.e. STI, BSD, CST, IEC, Mainstreaming, M&E, Finance) and TSU
- Nodal person will be responsible for coordinating with other SACS/TSU divisions and DAPCUs, industries associations, industries nodal persons, Department of Labour and Employment, department of health, etc.

- Nodal person would report to PD, SACS

ELM Coordination Committee at SACS

- Coordination committee at SACS will be headed by PD, SACS
- Following members are proposed to be part of ELM coordination committee at SACS
  - JD/DD/AD from all SACS divisions and departments (basic Services, STI, CST, IEC, TI Mainstreaming and M&E division)
  - Team leader TSU
- Coordination committee will meet on monthly basis

Experience has shown that formation of a coordination committee and continuous interaction with them through meetings helps in increasing the commitment of the senior management for the programme. Thus it is highly advisable to have a functional coordination committee in each company.

Roles of Coordination Committee at SACS

- Support in facilitating ELM
- Integration of HIV/AIDS services at industry level
- Review progress of ELM
- Ensure coordination among various divisions and departments for smooth facilitation of ELM
- Address operations-related issues
- Provide technical inputs into employer-led interventions initiated to strengthen the same

7.5 National Level

Nodal person at DAC

- DAC-TI division will be the nodal department and program officer-TI division will be the nodal person for coordination with other departments and SACS on ELM
- Nodal officer will be supported by two PPP-Consultants (till 2017)

ELM Coordination Committee at DAC level

- It is proposed that ELM coordination committee at DAC level be headed by DDG-TI division

- The following members are proposed to be part of ELM coordination committee at DAC level
  - Divisional representatives from all DAC technical divisions and departments
  - PPP consultants at DAC (till 2017)
  - PIPPSE project nodal officer for ELM (till 2017)
  - Team leader NTSU
- Coordination committee will meet once a quarter

Roles of ELM Coordination Committee at DAC:

- Review state-wise progress of ELM
- Ensure coordination with other DAC divisions and department for smooth facilitation, technical support for ELM from DAC
- Address issues, challenges and gaps in implementation of ELM at state level
- Review, revise, modify strategies as needed to strengthen facilitation of ELM at state level
- Provide technical inputs for employer-led interventions initiated to strengthen the same

Approaching Industries to Initiate ELM

SECTION 9

Activities to be Considered/Implemented by SACS for Entry into Industries

PSUs

- DAC as part of the mainstreaming activities is in the process of signing MOUs with 21 ministries at the central level. The memorandum of understanding (MOU) signing with central ministries governing various PSUs will facilitate access in respective PSUs for ELM. E.g. Signing of MOU with Ministry of Shipping is expected to facilitate access to all ports for implementation of ELM
- **Access to state-level PSUs will be facilitated by SACS through approaching ministries concerned with industries at state level**
- **Approach through industry associations:** Employer's associations can play an important role in facilitating access to employers in public sector industries. The state-level/district-level industry associations will be tapped for mobilizing industries

Private Sector Industries in Organized Sector

- **Positioning ELM as part of CSR activities:** Schedule VII of Companies Act 2013 for CSR includes HIV/AIDS as one of the 10 areas that industries can consider for CSR activities. This is an opportunity to mobilize industries as resources invested through ELM for informal workers and supply chain can be showcased under CSR activities. This will be an added advantage for large industries which can report activities under ELM as part of their sustainability reporting
- **Approach through state-level industry associations:** Employer's associations can play an important role in facilitating access to employers in private sector industries. The state-level/district-level industry associations will be tapped for mobilizing industries
- **Approach through national level industry associations:** At the national level, industry associations will be approached for conducting sensitization meetings with industry leaders and member industries
- **Access to industries with presence in more than a state:** At the central level, DAC will spearhead efforts to sign MOUs with central ministries controlling PSUs. This will facilitate access to PSUs with nationwide operations. DAC will also spearhead effort to reach private corporates and industries with national-level operations to engage them in rolling out ELM

Schedule VII of Company Bill for CSR includes HIV/AIDS as one of the 10 areas that industries can consider for CSR activities. This is an opportunity to mobilize industries as resources invested through ELM for informal workers and supply chain can be showcased under CSR activities.

- Integrating HIV and AIDS activities within industries already implementing TB programme activities in collaboration with the Revised National Tuberculosis Programme (RNTCP)

Unorganized Sector

- **Use of occupational health and safety programmes:** HIV/AIDS programme activities can be integrated within existing occupational health and safety programmes
- **Working with State Department of Labour and Employment** to include HIV/AIDS activities as part of occupational health and safety programmes at industry level in some key industrial sectors vulnerable to HIV/AIDS
- **Work through health activities mandated to industries which form part of supply chain of leading international brands:** E.g. Levi Strauss, a leading international garment brand, has regulation that supply-chain industries should implement HIV/AIDS prevention activities for their employees. Such systems can be identified and tapped for mobilizing industries in unorganized and small-scale sectors for ELM
- **Tap regulatory or statutory systems:** HIV/AIDS activities can be included as part of regulatory or statutory systems for certain supply-chain industries of bigger enterprises and its compliance be made mandatory for industries. E.g. While issuing RFPs (requests for proposals) or issuing contracts for major PPP projects, public works and so forth, could insist upon employee/ contractor/vendor to implement HIV/AIDS activities, the onus for this could rest with successful bidder or leader of successful consortium

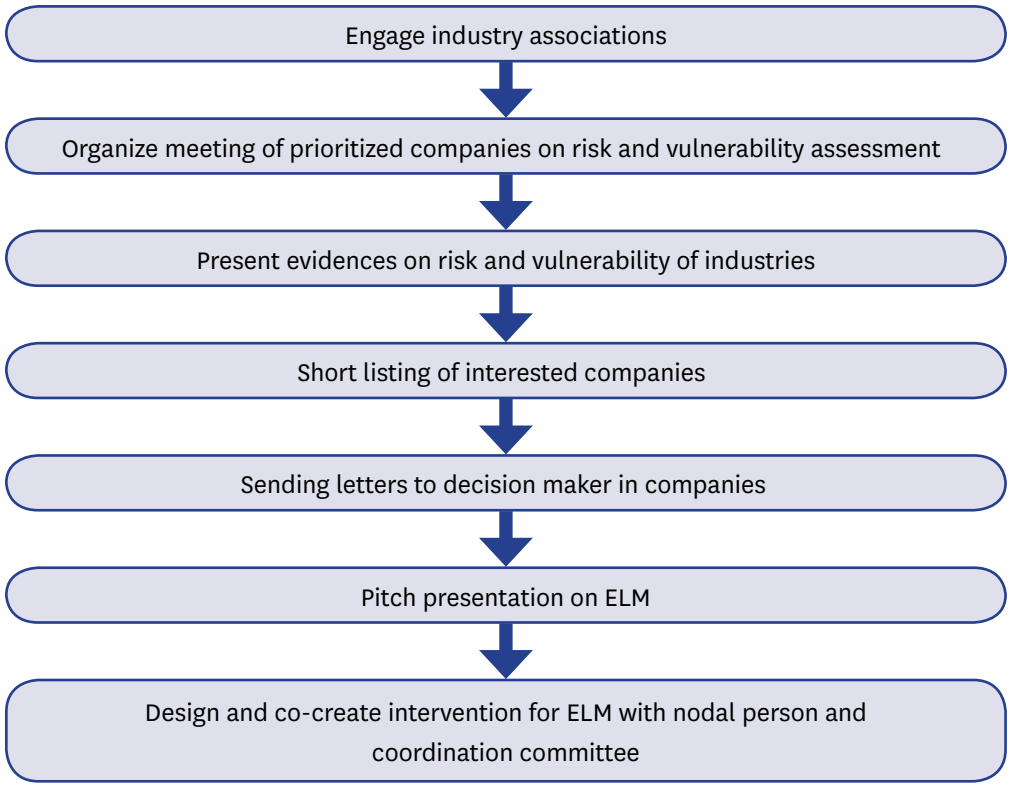
District administration can be mobilized for conducting advocacy meetings with industries. District collectors can be important stakeholders for mobilizing industries at district level for implementing ELM.

- **Leverage statutory systems as part of industrial banks lending money to industries:** Industrial banks such as IDFC, ILFS can be approached for including HIV/AIDS activities as a requirement for industries to qualify for receiving financial support from industrial banks
- **Creating access through district administration and labour commissioners:** District administration can be mobilized for conducting advocacy meetings with industries. District collectors can be important stakeholders for mobilizing industries at district level for implementing ELM. Similarly, labour commissioners at state or district level can be mobilized for advocacy with industries and motivating industries for implementing ELM
- **Approach through industry associations**
  Some unorganized sectors also have local associations which would be important stakeholders for creating entry within these industries
- **Engaging central-level institutes for training of unorganized sector on HIV/AIDS:** At central level, institutes such as Central Board of Workers Education (CBWE) will be engaged for conducting training on HIV and AIDS for workers in unorganized sector

Overarching Strategies for Creating Access to Industries

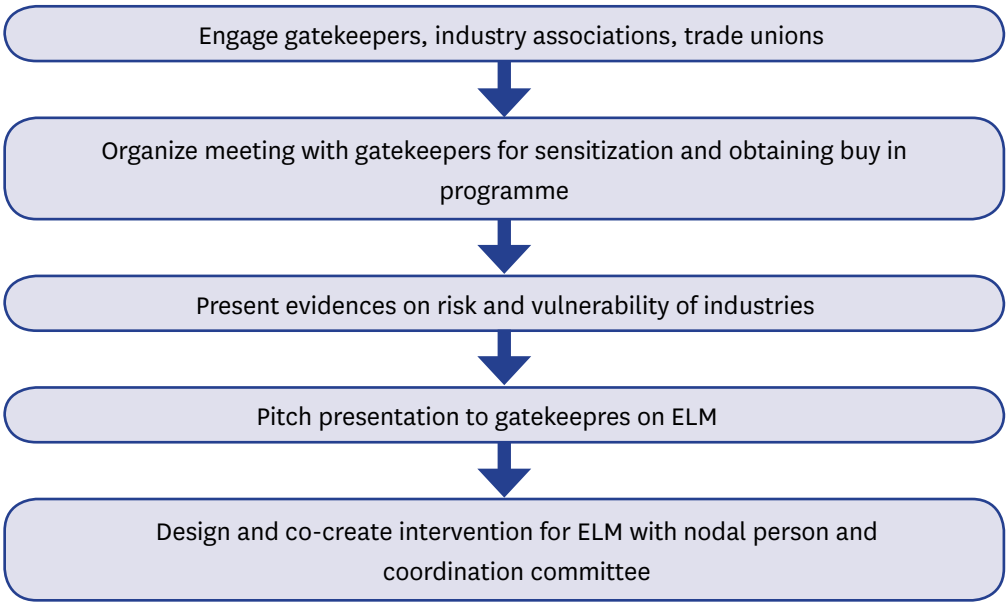
- **Industry champions from across industries:** A pool of industry champions will be identified among industries which have already implemented HIV/AIDS interventions. Champions will advocate HIV/AIDS programme in meetings of industry representatives through industry associations

Organized Sector (PSUs and Corporate Sector)



Detailed letter of introduction to industries and sample of pitch presentation included in Annexure 8.

Unorganized Sector Industries



Framework on systems and structures that can be leveraged for ELM is included in Annexure 7.

- **Advocacy kit for sensitization and advocacy with employers:** The advocacy kit will be developed for facilitating SACS for advocacy with employers of various sectors on ELM. The kit will consist of audio-visual materials, direct mailers, communication material for influencing top management of industries

Roles and Responsibilities: The following chart explains key activities, specific roles and responsibilities of stakeholders for approaching industries to initiate ELM.

Key Activities	Role of Employer/ Employer Associations	Role of SACS/TSU	Role of DAC
Advocacy with employers' associations, societies, federations for reaching out to industries for ELM	• Facilitate meeting with member employers	• Engage employer associations, federations, cooperatives, societies • Advocacy with gatekeepers with objective to reach prioritized sectoral industries for ELM • PD SACS may lead activity by convening meeting of industry association, chambers, ministry of labour	• Developing materials, tools for advocacy with gatekeepers • Technical support to SACS/TSU at state level for conducting advocacy meetings
Approaching prioritized industries, making first contact	• Contribute time and resources for the meetings at industry level • Support to identify systems and structures at industries	• Establish contacts with decision makers • Making pitch for ELM to industry • Follow up with prioritized industries	• Tools for pitch presentation with industries • Provide technical support to SACS at state level
Identify existing structures and systems with in industry and facilitate developing proposal for ELM	• Work with SACS/TSU to develop industry-specific proposal for ELM • Identify existing systems and structures within industries	• Inventarisation of systems and structures • Facilitate identifying existing structures and systems at industry level • Facilitate proposal for ELM at industry level	• Develop sample proposal formats • Ongoing technical support to SACS/ TSU for facilitating proposals

Sensitizing Decision Makers at Industry Level

10
SECTION

10.1 Introduction

Decision maker in this context are senior management at the organized industry level and associations, societies, cooperatives, trade unions in the unorganized sector. Sensitizing decision maker is crucial for a successful HIV/AIDS intervention at industries through ELM. Experience has shown that without leadership and involvement of decision maker (such as senior management in formal sector), there is a possibility of the programme becoming a peripheral activity and getting compromised. One needs to use this platform to sensitize decision maker about the gravity of HIV/AIDS as a workplace issue and emphasize its importance in the programme for effective implementation. Also, the decision maker sensitization and training programme will set the platform for joint planning of programme activities using existing resources, systems and structures for HIV/AIDS intervention.

Specific Objectives

- Sensitize decision maker about HIV/AIDS as a workplace issue and understand its ethical and legal implications
- Sensitize decision maker to risk and vulnerabilities of industry workers especially that of migrant informal workers towards HIV/AIDS
- Sensitize on the implication of HIV/AIDS on business of a particular sector as well as on overall economy
- Role of employers in building a brand image of corporate citizen
- Explain company-specific HIV/AIDS intervention strategy to decision maker
- Jointly plan company-specific HIV/AIDS intervention strategy using existing systems and structures within companies. Request them to give instructions to relevant departments on supporting programme in terms of time and resources
- Ensure involvement of gatekeepers in planning and implementation of programme by formation of coordination committee

Target group

Sector	Type of Industry	Possible Decision Makers
Organized sector	PSUs	Senior management of company. Includes directors, CEO, department heads, etc.
	Corporates	Senior management of company. Includes directors, CEO, department heads, etc.
Unorganized sector	Small and medium Enterprises	SSI associations, SSI employers Societies, Co-operatives and Trade Unions
	Construction sector	Builders association, builders, contractors, subcontractors
	Tea plantation	Tea plantation owners, tea plantation associations, contractors, subcontractors, trade unions
	Rickshaw and taxi	Taxi and rickshaw unions

10.2 Tools and Material

- Powerpoint (PPT) presentation and its broad contents:
  - Sharing broad findings of risk and vulnerability assessments, at national and local levels
  - Focus on factors that put migrant informal workers at risk and vulnerable to HIV/AIDS and its further implications
  - Focus on how industries/association/cooperatives/societies can support in reducing risk and vulnerabilities
  - How existing systems and structures can be used for HIV/AIDS intervention
  - Approximate cost of intervention and rsources to be shared by SACS
  - How HIV/AIDS programme will benefit the company
- Use PPT with discussion points as notes
- Question and answers

Discuss Plan and Components for HIV/AIDS Intervention Using Company Systems and Structures

- To build consensus among senior management on company-specific strategy for implementation of HIV/AIDS programme
- To draw implementation plan in collaboration with senior management
- To ensure ownership of programme among senior management

10.3 Roles and Responsibilities

Key Activities	Role of Employer	Role of SACS/TSU	Role of DAC
Sensitizing gatekeepers	• Organize decision makers sensitization in the industry • Contribute resources for conducting decision makers sensitization	• Identify decision makers at industries • Facilitate decision makerssensitization by industries • Conduct sensitization at SACS/Regional level	• Provide technical support as required at state level

Sample letter of Introduction and Pitch Presentation for sensitization is included in Annexure 8

Adapting HIV/AIDS Policy

11

SECTION

11.1 Introduction

The Ministry of Labour and Employment and the Department of Aids Control, Ministry of Health and Family Welfare, have jointly developed the National Policy on HIV/AIDS and the World of Work. The Policy is based on, and builds upon, the broad framework and ideology of the HIV/AIDS Policy of the Government of India. The national policy stresses that the organized and unorganized sector of industry needs to be mobilized for taking care of the health of the productive sections of their workforce

The National HIV/AIDS Policy will be followed in the Employer Led Model. The details of National HIV/AIDS Policy are available on the website of Ministry of Labour and Employement (MoLE)

HIV/AIDS policy helps industry

- Ensure consistency with national and international norms, guidelines and laws to provide clear statement about non-discrimination
- Give guidance to supervisors and managers about sensitive and ethical handling of HIV/AIDS related issues in the company
- Build an open and supportive environment for employees who could be already infected with HIV/AIDS

The National HIV/AIDS Policy will be followed in ELM. Details of National HIV/AIDS Policy are available on the website of Ministry of Labour and Employment (MOLE).

SACS will facilitate linkages of industries which wish to adapt the HIV/AIDS policy to the department of labour, mandated for implementing the National HIV/AIDS Policy at industry level.

The policy should be signed by appropriate signing authority in the company. A company may like to do it ceremoniously to coincide with a significant day. E.g. World AIDS Day, Workplace Safety Day, Foundation Day, etc.

11.2 HIV/AIDS Policy in PSUs and Large Private Sector Companies:

Some ways in which companies can develop policies:

- Developed by HR Department and adopted, after due deliberation, by different stakeholders including senior management and workers' representatives
- Through deliberation between company management and workers' representative
- Include suggestions of workers' representatives in policy development to make process more participatory. Depending on company culture this step is optional

Adoption of Policy

The policy should be signed by appropriate signing authority in the company. A company may like to do it ceremoniously to coincide with a significant day. E.g. World AIDS Day, Workplace Safety Day, Foundation Day, etc. This could be done as a part of the event attended by employees to facilitate better dissemination of the policy.

Dissemination of Policy

To ensure that the policy is useful, a good dissemination plan is necessary.

- The policy could be translated in the local language
- Copies of policy both in English and local language could be framed and displayed at strategic locations such as company entrance, canteens, recreation rooms, medical departments and each department

11.3 HIV/AIDS Policy in Unorganized Sector

In the unorganized sector, following stakeholders can adopt the HIV/AIDS policy

- Trade unions
- SSI associations
- Sector-specific federations, societies and cooperatives of unorganized sector
- Contractors
- Sector-specific employer associations e.g. builders associations

11.4 Ethical Standards and Maintaining Confidentiality

Confidentiality is a cornerstone of high quality HIV/AIDS/STI services. In all circumstances, patient confidentiality should be ensured as per the National HIV/AIDS Policy and guidelines of NACP. This means:

- Information about patient should not be communicated to third parties outside clinic, and patient should be made aware of this policy
- HIV/AIDS service-related records and registers should be kept locked
- In all aspects, basic human rights of each patient must be respected and given utmost importance
- All examinations, procedures and treatments should be clearly explained to and be understood by patient prior to testing or treatment
- Patient must have option of refusing any or all services at clinic

Outreach for HIV/AIDS Awareness

12

SECTION

12.1 Background

Awareness on HIV/AIDS prevention products and services is one of the key strategies for reducing the risk of informal workers at the industry level. Existing systems and structures within the industries is proposed to be used for integrating HIV/AIDS awareness activities.

The following table explains the type of industry and systems/structures that can be used for integrating awareness activities.

Type of Industry	Awareness on HIV/AIDS Prevention Products and Services
Organized Industries PSUs and large private sector companies (manufacturing industries such as cement, steel, automobile, textile, etc. which employ vulnerable, migrant informal workers)	• Comprehensive health and safety programme and trainings for integrating HIV/AIDS awareness programme • HR induction trainings, welfare programmes for integrating HIV/AIDS awareness programme • Using employee volunteers as outreach workers for creating awareness • Training of medical doctors and para medical staff • Health & Safety Staff, Supervisor, contracts to be trained in outreach awareess • Forming street playgroup from employee volunteers for mid media activities • Social and educational activities within companies for integrating HIV/AIDS awareness programmes • Officers' wives clubs for creating awareness among female informal workers • Organizing recreational events on World Labour Day (1st May) World AIDS Day or Foundation Day to foster employer relations and create awareness among informal workers
Unorganized Sector (Construction, harvesting, plantation, quarry mining, etc.)	• Using gatekeepers such as contractors/subcontractors/trade union leaders, etc. to be peer educators/master trainers • Employee volunteers from informal workers to be trained • Contractors, supervisors to be trained in Outreach awareness • Sensitizing employers/associations to make HIV/AIDS activities mandatory as part of contractual clause with contractors • Integrating HIV/AIDS within comprehensive H&S programme through CSR of employers/associations (e.g. builders can contribute resources for construction workers' programme)
Medium Industries and SSI	• Using existing trainings, social platforms of SSI associations for integrating HIV/AIDS activities • Using employee volunteers from other big industries to create awareness and demand creation activities within SSI area • Training of employees, supervisors, contractors from selected units to be trained for awareness activities

II] Outreach Awareness Activities in Organized Sector (PSUs and Private Companies)

- Outreach activities: Medical and para medical staff, supervisors, contractors and employee volunteers would be trained for conducting outreach activities in one-to-group sessions.

Trained staff at industry level will conduct these sessions with informal workers to create awareness on HIV/AIDS.

Outreach awareness sessions may also be integrated within regular health and safety programmes, HR trainings, welfare activities to build in continuity and sustainability of awareness activities

- Mid media campaigns: Mid media techniques will be used to create interest and generate awareness among large number of people. Employee volunteers from industry can also take initiatives to conduct mid media activities on regular basis to reach informal workers. Industries are expected to contribute time of employee volunteers, resources for organizing mid media activities on regular basis
- Development of IEC/BCC materials: Standard prototypes for IEC and BCC materials will be made available to industries through SACS/TSU. IEC/BCC material may be printed by industries as per prototypes provided by SACS according to needs of community and migrant informal workers
- SACS will also facilitate provision of resource kits containing following items for informal workers through employers. SACS will support to develop state-specific resource kit
  - Information on HIV/AIDS/STI
  - Condom packs
  - Details of ICTC/ART centre at destinations and source states
  - Information on central and state-level social welfare schemes for migrants

I] Outreach Awareness Package for Unorganized Sector and SSIs

- **Outreach activities:** Supervisors, contractors, subcontractors, volunteers from among workers would be trained for conducting outreach activities in one-to-group sessions with informal workers. Awareness activities will also be regularised through advocacy with associations, federations and societies of informal workers
- **Mid media campaigns:** SACS-led mid media activities will be used to create interest and generate awareness among informal workforce to begin with. Employee volunteers from informal workers can also be trained for conducting small activities of entertainment involving HIV/AIDS/STI among themselves
- **Development of IEC/BCC materials:** SACS can facilitate IEC material for informal workers in unorganized sector. Effort can be made to leverage support from owners, associations, federations and societies of unorganized sector. Unorganized sector forms supply chain of many large and big industries. Support can also be leveraged from these industries for conducting HIV/AIDS activities
- SACS can facilitate provision of a resource kit containing information on HIV/AIDS/STI
  - Information on HIV/AIDS/STI
  - Condom packs
  - Information on central and state-level social welfare schemes for migrants

12.2 Framework for HIV/AIDS Training for Medical Staff, Supervisors from Industry

To ensure that there is a capacity building in the industry to have a sustainable HIV/AIDS intervention, it is advisable that a set of employees are trained on HIV/AIDS. This trained group of people should undergo a one-day training programme and be called peer educators. They can spread information on HIV/AIDS to their colleagues through formal and informal sessions. This section includes a detailed one-day training framework.

Topic	Specific Objectives
Basics of HIV/AIDS/STI (different dimensions of HIV/AIDS, immune system, routes of transmission, myths about HIV transmission, prevention HIV testing, symptoms, treatment of OIs/ART)	• To enhance knowledge level of participants on HIV/AIDS
Vulnerability of migrants for HIV/AIDS	• To emphasize the need of Employer led model at the industry level
Sharing perspective of PLHIV	• To provide interface with PLHIV • To orient participants on issues of stigma and discrimination associated with HIV/AIDS
Condom education and accessibility at workplace	• To explain need for condom promotion and approaches in HIV/AIDS prevention programmes • To discuss key barriers to condom use
Explaining use of IEC materials/training manual	• To orient participants on trainers' kit and manual • To explain use of IEC materials (leaflet/poster/presentation CD /film, etc.)
Practice sessions using IEC material e.g. flip chart, flash cards, Card Game	• To enable the participants understand the IEC material, flash cards, HIV/AIDS card game and its use

12.3 IEC and Communication Materials

This section enumerates some of the communication tools being used in HIV/AIDS interventions in industries.

Examples of Industry Specific Materials

- **Card Games**

  The HIV/AIDS card game can be used for conducting sessions by contractors/supervisors/employee volunteers. It is a pack of 20 cards of questions and answers on STI/HIV/AIDS. Questions 1-6 are on basic information on HIV/AIDS and routes of transmission, question nos. 7-13 are on the prevention of STI/HIV/AIDS. The rest are on issues of testing, treatment, stigma, discrimination and rights of PLHIV.

- **Flash Cards**
  HIV/AIDS flash cards for migrant interventions can be used for intervention with industry workers. Basic steps for conducting sessions with flash cards need to be taught to peer educators during training programme
- **Flipcharts**
  Flipcharts made for migrant interventions can be used for intervention with industry workers
- **HIV/AIDS Pamphlets and Leaflets**
  Pamphlets and leaflets on STI, ICTC, condoms can be used and made available at sites such as clinics, entry gate of industries, canteens, shop floors, etc. which can be easily accessible to informal workers within industries

12.4 Roles and Responsibilities

Key Activities	Role of Employer	Role of SACS/TSU/DAPCU	Role of DAC
Awareness and demand creation for HIV/AIDS prevention, services and condoms Who will create of awareness: • Existing medical and paramedical staff • Supervisors • Employee volunteers from industries as peer leaders for conducting awareness sessions	• Identify systems in HR welfare, H&S programme • Contribute time of identified employee volunteers, medical staff, supervisors for training • Contribute infrastructure for conducting trainings • Contribute resources for printing of IEC materials, communication tools • Reporting of data on awareness activities with SACS	• Facilitate training and capacity building at industry level • Provide hand holding to industries for keeping trained volunteers motivated for conducting awareness activities • Providing prototype of IEC material, communication material to industries	• Develop training manual for training of employee volunteers, supervisors and medical staff at industry level • Develop guidelines, tools for awareness activities • Build capacities of SACS/TSU for conducting training of peer leaders • Provide ongoing technical support to SACS/TSU for conducting trainings at industry level

Integrating HIV/AIDS Services within Health Facilities Linked with Industries

13

SECTION

13.1 Introduction

Many industries in the PSU and private corporate sector implement health facilities for providing medical services to employees as part of employee-welfare activities. Health facilities vary across industries, depending on the scale of industry, number of employees and infrastructure available. Health facilities are often extended to contractual workers and communities near the company.

Health facilities linked with industries may be leveraged for integrating HIV/AIDS prevention to care services, depending on infrastructure and human resources available at these facilities.

The following HIV/AIDS prevention to care services may be integrated within industry-linked health facilities.

- STI management
- ICTC services
- PPTCT services
- Anti Retroviral Treatment and Care Support Services

Types of health facilities linked with industries and HIV/AIDS services that may be integrated:

Type of Industry-Linked Health Facility	Resources Available	HIV/AIDS Services that May be Integrated
Health clinic setup at plant level	• Medical doctor • Staff nurse • Laboratory staffs	• STI management • ICTC services
Hospital setup	• Key medical department • Laboratory staff • Nursing staff	• STI management • ICTC/PPTCT services • ART center

Services can be extended to formal workers and nearby communities as well, based on company policies.

Many industries in the PSU and private corporate sector implement health facilities for providing medical services to employees as part of employee-welfare activities. Health facilities vary acrossindustries, depending on the scale of industry, number of employees and infrastructure available.

13.2 Steps Proposed in Integration of HIV/AIDS Services and Responsibilities

Steps	Responsibilities at SACS Level
• **Discussion with senior management of company:** i. Sensitization of senior management on proposed services to be integrated at State/Regional level ii. Detailed presentation on need for services, types of services and roles of partners at State/Regional level iii. Cost implications and supports to be provided by SACS/TSU at State/Regional/Industry level to prepare MoU iv. Expected benefits v. Institutional arrangements vi. A coordinating committee established in company would be useful for advocacy with senior management	TI division
• **Facility assessment:** i. Conduct assessment of health facility in which integration is proposed by team consisting of representatives from STI, basic services and CST division at SACS level, as per guidelines ii. Facility assessment may be focused on understanding resources available at health facility in terms of infrastructure, human resources that can be leveraged for HIV/AIDS services iii. Training needs and expected patient load v. Assessment of systems	Joint team of representatives from BSD, STI and CST division to facilitate the process may be by field visits or through self reported questionaire/tools
• **Signing of MOU with industry for integrating HIV/AIDS services:** Current MOU for ICTC, STI and ART services can be adapted for ELM	SACS
• **Training of health care providers:** It's recommended to conduct training of health care providers on types of services that are proposed to be integrated within health facilities	Joint team of representatives from BSD, STI and CST division AAP target to be set for the corrent year to be accomplished and target for next year should be set accordingly
• **Full-site sensitization:** All staff in facility including superintendents of hospitals, nurses, administrative staff, pharmacists, X-ray technicians and ward boys, need to be sensitized about specific issues related to HIV/AIDS such as importance of HIV counselling, confidentiality, PEP, universal precautions and maintaining respectful and non-discriminatory attitude towards PLHIV	Joint team of representatives from BSD, STI and CST division

13.3 STI Management

STIs and reproductive tract infections (RTIs) are important public health problems in India. Studies suggest that 6 percent of the adult population in India is infected with one or more STI/RTI. Individuals

with STIs/RTIs have a significantly higher chance of acquiring and transmitting HIV. Provision of STI/RTI care services will be essential prevention services in ELM.

Detailed guidelines for STI Management Services are mentioned in Annexure 9

Framework for STI Services in Industry-Linked Health Facility

Type of Health Facility	Available Human Resources	Service Provision Modalities	Service Package
Clinic at plant level	• Medical doctor • Staff nurse	• Routine clinic • Outpatient care	• STI/RTI diagnosis and syndromic treatment • Counselling for STI and HIV/AIDS as per national guidelines • Condom promotion • Partner treatment • Referral to ICTC and other services (if necessary)
Hospital setup	• Medical doctor • Staff nurse • Laboratory technician	• Routine clinic • Outpatient care • Laboratory services	• STI/RTI diagnosis and syndromic treatment • Counselling for STI and HIV/AIDS as per national guidelines • Condom promotion • Partner treatment • Laboratory diagnosis (if necessary) • Referral to ICTC and other services (if necessary)

13.3.1 Roles and Responsibilities

Role of Employer	Role of SACS	Role of DAC
• Provide STI management as per national guidelines • Maintain confidentiality and privacy while providing services • Reporting to SACS on monthly basis in prescribed format • Maintain referral linkages for clients referred for further care • To ensure all drugs as per syndromic management guidelines are available at health facility • Ensure availability of IEC material, communication tools • Ensure availability of condoms at facility level	• Conduct training on STI/RTI management • Conduct full-site sensitization programme to ensure stigma-free environment • Provide on-site technical support to staff at health facility • Conduct support visits on monthly basis to ensure ongoing technical guidance to health facility • Provide Specification of days as per National guidelines	• Providing strategic direction in training and supportive supervision • Developing training modules; induction as well as refresher trainings, with relevant materials • Imparting training to trainers at SACS • Developing on-ground communication design and tools • Impart training on communication design to SACS

13.3.2 Mentoring and Support visits for STI Management

Who will monitor and supervise STI/RTI services at industry level: A coordination committee, consisting of members from industries, trade unions, SACS and association, would conduct quarterly monitoring of STI/RTI services using checklist of STI/RTI services **(Annexure 14)**

Reporting of STI/RTI Data

Who will report: The medical doctor at facility level will be responsible for filling up patient records and reporting to nodal officer who will compile overall report on ELM and send it across to SACS

Refer to Annexures 12 and 13 for reporting format, patient card format and register format for STI services

Standards for STI Management Services in Industry

Refer to Annexure 10 for detailed guidelines on:

- Minimum infrastructure required
- Equipment and supplies for STI/RTI services provision
- Minimum furniture and general items
- Other essential supplies for STI/RTI services provision
- Essential STI/RTI kits and drugs for clinics
- Minimum clinical management at private practitioners STI/RTI facility

The ICTC service is an important component of prevention and control of HIV/AIDS in the country. HIV counselling and testing services are a key entry point to prevention of HIV infection, and treatment and care of people who are infected with HIV.

13.4 ICTC Services

The ICTC service is an important component of prevention and control of HIV/AIDS in the country. HIV counselling and testing services are a key entry point to prevention of HIV infection, and treatment and care of people who are infected with HIV.

Detailed guidelines for ICTC services at industry level are mentioned in Annexure 10

Framework of ICTC Services in Industry-Linked Health Facility

Level of Care	Service Providers	Service Provision Modalities	Service Package
Clinic at plant level with labortory facility	• Medical doctor • Staff nurse • Lab technician	• ICTC services • Referral linkages for HIV-positive clients	• Pre-test and post-test counselling by staff medical doctor • HIV testing by staff nurse/lab technician • Referral linkages for HIV-positive clients
Hospital setup	• Medical doctor • Staff nurse • Laboratory technician	• ICTC • PPTCT • Referral linkages for HIV-positive clients	• Pre-test and post-test counselling by staff nurse or medical doctor • HIV testing by lab technician • Referral linkages for HIV-positive clients

13.4.1 Roles and Responsibilities

Role of Industry-Linked Health Facility	Role of SACS	Role of DAC
• Provide ICTC/PPTCT services as per national guidelines • Maintain confidentiality and privacy • Report to SACS on monthly basis in prescribed format • Maintain referral linkages for HIV-positive clients referred for further care • To ensure bio-waste management • To ensure adherence to universal precautions • Supply of test kits and consumables for HIV testing • Follows and participate in external quality assurance and internal quality assurance as per national guidelines • Ensure printing and availability of communication tools, IEC material, counselling tools and reporting formats	• Provide specification for the test kits, consumables and PEP drugs as per DAC guidlines • Conduct training of Provide Specifications for the Test kits, consumables and drugs as per DAC guidelines counsellor, lab technician and medical doctor for ICTC/PPTCT services • Conduct full-site sensitization program to ensure stigma-free environment • Provide prototype designs for communication tools, IEC material, counselling tools • Provide on-site technical support to the staff at health facility • Conduct support visits on monthly basis to ensure ongoing technical guidance to health facility • Provide linkages for supply of test kits • Provide linkages for external and internal quality control • Develop referral linkages to ART, care and support services	• Providing strategic direction in training and supportive supervision • Developing training modules; induction as well as refresher trainings, with relevant materials • Imparting training to trainers at SACS • Developing on-ground communication design and tools • Impart training on communication design to SACS

Training of Staff

- Training of health staff at industry-linked health facilities may be conducted as per training guidelines for ICTC services (refer to annexure for detailed training guidelines)
- Option of on-site training for counsellor and lab technician may be explored by deputing them at government ICTC centre

13.4.2 Mentoring and Support visits for ICTC

- Coordination committee consisting of members from industries, trade unions, SACS and associations, would conduct quarterly monitoring of ICTC services provided using checklist of ICTC services (Annexure 16)
- ICTC supervisors will be responsible for providing supporting visits to industry-linked ICTC services on monthly basis

Recording and Reporting

- Counsellor (staff nurse) at industry-linked ICTC centres will be responsible for maintaining patient records and reporting to nodal officer, who will compile overall report on ELM and send them across to SACS (See annexure for sample patient record for ICTC and reporting format to nodal officer)
- ICTC services indicators will be captured in monthly reporting formats of ELM (Refer to Annexure 15)

Standards for ICTC/PPTCT Services at Industry Level: Refer to Annexure 11 for detailed guidelines on:

- Minimum physical infrastructure required for ICTC
- Components of HIV counselling and testing
- Steps in HIV counselling
- HIV test result
- HIV testing and quality assurance
- Settings in which counselling may be offered to clients
- Training of health staff at industry-linked health facilities in national guidelines on ICTC/ PPTCT services

13.5 ART Services

One of the key objectives of NACP IV is to strengthen provision of care, support and treatment to all PLHIV. ELM will advocate including ART centres in health facilities linked with industries subject to the availability of basic infrastructure needed for ART services.

Detailed guidelines for ART and Care treatment services at industry level are mentioned in Annexure 11

13.5.1 Roles and Responsibilities

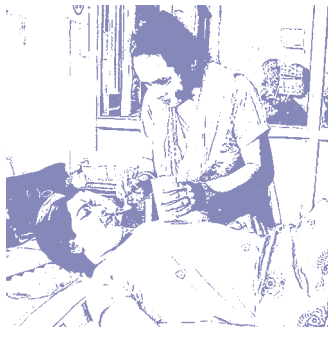
Role of Industry-Linked Health Facility	Role of SACS	Role of DAC
• Provide ART services as per national guidelines • Attend trainings organized by SACS • Maintain confidentiality and privacy while providing services • Reporting to SACS on monthly basis in prescribed format • Maintain referral linkages for HIV-positive clients referred for for ART, care and treatment services • Cover the cost of ART drugs for patients from within own industries • Share infrastructure and human resources for implementation of ART services • Ensure printing and availability of IEC material, counselling tools and reporting formats	• Conduct trainings of ART staff identified by industries • Conduct full-site sensitization programme to ensure non-discriminatory environment • Provide prototype of communication tools, IEC material • Provide on-site technical support to the staff at health facility • Conduct support visits on monthly basis to ensure ongoing technical guidance to health facility • Provide Specification of ART drugs as per national guidelines	• Providing strategic direction in training and supportive supervision • Developing training modules; induction as well as refresher trainings (once every year), with relevant materials • Imparting training to trainers at SACS • Developing on-ground communication design and tools • Impart training on communication design to SACS

13.5.2 Selection Criteria for ART Centre: The following criteria are to be used to set up ART Centres in PSU and private sector:

- Districts/Regions with high HIV sero-prevalence at ICTCs (greater than 500 positive people detected over last five years in catchment area)
- Geographic distribution of existing CST facilities in states and catchment area to be considered while proposing new ART centres
- Proposed site should be accessible and well connected by public transport
- Availability of adequate space (as per ART operational guidelines) for setting up ART centre within hospital campus, preferably in/near medicine OPD
- Willingness and preparation for providing necessary investigations (except CD4 and Viral load, if required) free-of-cost to PLHIV and make available, basic drugs for OI treatment in hospital pharmacy and essential drugs required for dealing with side-effects of ART
- Agreeing to follow ART technical and operational guidelines prescribed by DAC

13.5.3. Standards for ART Services at Industry Level: Refer to Annexure 12 for detailed guidelines on:

- Minimum physical infrastructure required for ART centre
- Steps for setting up ART centres
- Functions of ART centre
- Capacity building of ART centre staff



Medical doctor at ART centre will be responsible for maintaining patient records and reporting to nodal officer, who will compile overall reports on ELM and send them across to SACS

13.5.4 Mentoring and Support visits for ART Services

- Coordination committee consisting of members from industries, trade unions, SACS and associations would conduct quarterly monitoring of ART services provided, using checklist for ART services (Annexure 18)
- Representative from SACS-CST division will be responsible for providing supporting visits to industry-linked ART services on quarterly basis

Recording and Reporting

- Medical doctor at ART centre will be responsible for maintaining patient records and reporting to nodal officer, who will compile overall reports on ELM and send them across to SACS (See annexure for sample patient record and report format to nodal officer)
- ART services indicators will be captured in monthly reporting formats of ELM (Refer Annexure 17)

Integrating HIV/AIDS Services in Unorganised Sector and Industries without Health Set ups

14

SECTION

14.1 Introduction:

This chapter explains the operational guidelines for providing HIV/AIDS services to industries without health facilities.

Many industries in the unorganized sector and a few in the organized sector may not have health facilities linked. Providing HIV/AIDS services in such cases should be ensured by following these strategies:

Type of HIV/AIDS Services	Service Providers	Service Provision Modalities	Package of Services
STI/RTI diagnosis and syndromic management	• Hired allopathic medical doctor	• Periodic health camp at site level • Referral linkages to government centres	• STI/RTI diagnosis and syndrome treatment • Counselling for STI and HIV/AIDS as per national guidelines • Condom promotion • Partner treatment • Referral to ICTC and other services (If necessary)
ICTC services	• ICTC services through SACS	• Mobile ICTC • Referral linkages to government ICTC service	• Pre-test and post-test counselling • HIV testing • Referral linkages for HIV positive clients
ART services	• Government ART services	• Referral linkages to government ART services	• Care, support and treatment services to all PLHIV and monitor patients in HIV care (Pre-ART) regularly • Identify eligible PLHIV requiring ART and initiate them on ART • Provide ARV & OI drugs

14.2 STI/RTI Diagnosis and Syndromic Management: Periodic-a-month, on-site heath camp at company level.

Process for organizing on-site health camp will be as follows:

- Discuss with coordination committee at industry level to identify locations where on-site camps can be organized.
- Mobilize industry to allocate space (room minimum of 10 x 10 feet) for organizing health camp
- Map and select allopathic private practitioner from nearby industry to conduct health camps on monthly basis at industry. The doctor/panal of doctors required to be trained
- Finalize date suitable every month for organizing camp
- Training of selected private provider to offer STI syndromic management

14.2.1 Package of Services to be Provided Through Health Camp

Category of Provider	Inputs	Additional Support	Package of Services Expected
Doctor (private practitioner) Allopathic (MBBS Doctor)	• Training • Regular support	• General medicines STI drugs from company/ association/ cooperative • Referral list for ICTC • Referral list for lab tests • Referral list of ARV	• Syndromic diagnosis general health check up • Syndromic treatment (patient STI treatment and partner)- dispense/prescribe medicine • Follow-up visit • Counselling • Referral to ICTC

Cost of Services: Negotiate with the medical doctor for cost of treatment and consultation. The cost of treatment is to be paid to the doctor by the company/industry/association/cooperative. The coordination committee at industry level will be responsible for coordinating the payment of medical doctor for conducting health camps.

Hire allopathic medical doctor for conducting Health Camps at Industry Sites on monthly basis. The cost of treatment is to be paid to the doctor by the company/ industry/association. The coordination committee at industry level will be responsible for coordinating the payment of medical doctor for conducting health camps.

14.2.2 Monitoring and Supervision:

The coordination committee, consisting of members from industries, trade unions, SACS and associations, would conduct quarterly monitoring of health camps provided, using checklist (Annexure 14).

Monitoring of Services in Unorganized Sector:

On unorganized sector sites, representatives from various stakeholders, such as trade unions, contractors, federations, co-operatives, societies, associations, etc. need to be identified for forming the coordination committee. The list of stakeholders will vary from industry to industry. The representatives from SACS/DAPCU should be part of the coordination committee to facilitate the overall process.

Recording and Reporting:

- Medical doctor attending health camp will be responsible for maintaining patient records and reporting to nodal officer who will compile overall report on ELM and send it across to SACS (See annexure 13 for sample patient record and reporting format to nodal officer)
- STI/RTI services indicators will be captured in monthly reporting formats of ELM (Refer to Annexure 12 and 13)

14.2.3 Role of SACS

- Provide initial, refresher training
- Provide training materials and job aids
- Provide specification of drugs as per national guidelines
- Provide IEC materials for free distribution
- Provide reporting formats
- Provide supportive supervision on a regular basis

Role of Employer

- Support the consultation charges of Doctor
- Provide Space for Conducting Halth Camp with adequate privacy
- Contribution for STI drugs and general drugs contribution for
- Reporting of data through nodal officer

Role of Health Camp Doctor

- Provide STI/RTI management, according to national guidelines
- Provide health education for treatment compliance, condom promotion and partner treatment
- Provide referrals to ICTC, higher STI/RTI centres and other medical/surgical services as required
- Document data of each STI/RTI treated, in format provided, and share data with nodal officer on monthly basis

14.3 ICTC services

Link Up Mobile ICTC Services to Industry: The process will be as follows.

Sensitize coordination committee and gatekeepers

- Re-emphasize need and importance of providing ICTC services for informal workers
- Sensitize coordination committee and senior management on confidentiality and anonymity issues in providing ICTC services
- Discuss with coordination committee at industry level for providing ICTC services through mobile ICTC may be supported from SACS
- Identify location at plant level and days when it will be convenient to provide mobile ICTC services at industry level

Link up mobile ICTC of SACS to industry

- Allocate days for industry intervention in the planned journey cycle of mobile ICTC every month
- Coordinate with the nodal person in the coordination committee to finalize the days for mobile ICTC intervention at industry level
- Coordinate with the peer educators trained at the industries for creating awareness on the mobile ICTC availability at the industry level

Activities on the day of mobile ICTC visit

- Discuss with coordination committee so that contract workers can be released for HIV/AIDS counselling and testing
- Coordinate with peer educators for mobilizing clients for HIV/AIDS counselling and testing
- Peer educators can support crowd management on day of mobile ICTC visit

14.3.1 Mentoring and Support visits

- Monitoring of supervision of mobile ICTC services will be conducted as per national guidelines for ICTC and conducted by SACS

- Nodal officer and coordination committee will coordinate with SACS regarding visits of mobile ICTC at industry site

Recording and reporting

- Recording of ICTC conducted at mobile ICTC will be followed as per national guidelines
- Mobile ICTC counsellor will be also provide feedback to nodal officer in industry to keep industry representatives in loop about ICTC conducted each month, so that it is recorded in monthly reports
- Due confidentiality will be maintained by counsellor and nodal officer regarding data

14.4 Referral Linkages with Government ICTC/ART Services

The process will be as follows:

Referrals to ICTC/ART services through regular health camps

- List of ICTC services in district would be shared with medical doctors conducting health camps at industry level
- STI cases would be referred by medical doctor to ICTC services by using coded referral slips (refer to Annexure 20 for sample of referral slip)
- Tracking mechanism will be developed for clients referred from health camps
- At all ICTC services, counsellors will be briefed about code of referral slips from industries and maintaining records of referral slips
- Medical doctor from industry will be responsible for collecting data on no. of clients accessing ICTC services through referrals from ICTC services

Referral linkages through Outreach activities

- List of ICTC services in district would be shared with supervisors, contractors trained in Outreach
- The demand and awareness of ICTC Services would be created through one to one and one to group sessions by medical doctor/supervisors/contractor
- The supervisors, contractor to provide colour-coded referral slips with industry code to clients referred for ICTC services
- Tracking mechanisms to be in place for clients referred from Industries
- Data with respect to no. of clients referred to ICTC per month will be collected by nodal officer and passed on to SACS in monthly reports

Referral linkages from industries to public health services for ART, care and treatment services

- Clients from industry will be referred for ART and care and treatment services using referral slips with industry code (refer to Annexure 20 for suggested sample of referral slip)
- ART and Care Support centres will maintain records of clients referred from industries
- Medical doctor/nodal officer at industry level will collect data from ART and Care Support centres for tracking of referrals

TB and HIV Linkages

15

SECTION

15.1 Introduction

India is the highest TB-afflicted country in the world, with over 1.9 million estimated TB cases per year. HIV infection makes individuals more susceptible to contracting TB. Nearly 50–75 percent of those affected by TB and HIV are adult men and women in the economically productive years of their life. There is growing recognition about the impact of TB on productive age group and thus businesses. Revised National TB Control Programme (RNTCP) is implementing TB prevention to care projects in 150 companies.

This provides good opportunity for tapping these companies to integrate HIV/AIDS prevention programs within existing TB programmes. Similarly TB programme activities can be integrated within HIV/AIDS programmes at industries implementing HIV/AIDS programmes.

15.2 Key Sectors with TB and HIV-Risk Factors

Sector	Potential Risk Factors
Mining industry	• Occupational exposure to silica dust and silicosis • Confined, poorly ventilated working environment • Cramped living quarters • Increase vulnerability to HIV
Businesses with large migrant workforce	• Increased vulnerability to HIV • Poor living conditions • Poor access to health care • Overcrowding
Construction	• Exposure to silica dust • Poor living conditions • Alcohol use • Poor access to health care
Oil and gas industries and plantations	• Cramped and congested living area • Poor access to health care
Transport sector (and other mobile work forces)	• Increased risk and vulnerability to HIV • Poor access to health care as TB care can only be organized as part of targeted workplace programme, fixed sites for DOT are not possible

15.3Steps to be carried out for HIV-TB linkages:

- Identify industries implementing TB programs as part of PPM through State RNTCP programme
- Approach industries for integrating HIV/AIDS programme within same structures and systems of TB programme activities
- For industries which are yet to begin with TB or HIV programmes, advocate for integrated TB and HIV programmes
- Facilitate TB programme activities through state RNTCP programme

TB Activities that can be Integrated within ELM Framework

Areas	Key Activities
Improved awareness and knowledge of TB and HIV	All workers should at least be aware of symptoms of TB and when, where and how to seek TB diagnosis and treatment. Awareness activities can be integrated at two levels within workplace • Senior management training and sensitization programme by adding session on Tuberculosis and HIV/TB co-infections • Peer education programmes by adding sessions on awareness of symptoms of TB and where and how to seek diagnosis and treatment
Diagnosis and counselling in case of industries linked with health facilities	Businesses could contribute to early detection of TB by facilitating access to sputum testing and counselling services for employees, and/or dependents, on site or in collaboration with RNTCP • Setting up on-site microscopy/diagnostic centre in collaboration with RNTCP • Facilitating access to TB and HIV counselling services for employees, and/or dependents • Referral linkages with ICTC and TB services for providing counselling to workers
Referral and treatment support for unorganized sector and industries not linked with health facilities	Intensified TB case-finding (TB screening), referral of people with TB symptoms, and treatment adherence support • Medical, paramedical staff, human resource personnel and workers (peer educators/counsellors) can be trained to identify TB symptoms, refer people with symptoms for diagnosis or provide treatment • Establishing referral mechanisms to TB and HIV service providers within public and private sectors in collaboration with RNTCP • Training of medical, paramedical staff and workers to act as treatment adherence supporters
Access to care and treatment	Industries can facilitate access to TB treatment and care through provision of treatment support on-site • Providing treatment at an easy and accessible point for employees or referring employees to linked public/private treatment facilities; • Providing employees time off for treatment during infectious phase without employment repercussions and also allowing patients, who receive treatment outside company premises, time to access it every day.

15.4 Monitoring and Evaluation

- In case of industries already implementing TB programme activities, HIV/AIDS programme indicators can be added within existing monitoring framework
- Monitoring and supervision of TB programme activities will be conducted in collaboration with RNTCP and coordination committee at industry level

Condom Availability at Industries

16

SECTION

16.2 Networking with Social Marketing Organisation (SMO)/Public Health Facility

The employer can be linked with SMO operating at the location and/or the public health facility from where free condoms (nirodh) can be procured. It may be noted that while establishing new condom outlets is important, ensuring absence of stock-outs and availability at convenient timings and locations. Nodal officer should take the initiative to estimate the requirement and coordinate with SACS/SMO to ensure stock availability. Many will be willing to pay for preferred condom brands. The principle of 'first expiry, first out' should be adopted while distributing condoms.

Nodal officer should take the initiative to estimate the requirement and coordinate with SACS/ SMO to ensure stock availability.

16.3 Role of SACS/DAPCU

To facilitate the linkages between Industry and SMO. Regular monitoring of vending machines, facilitating repair/maintenance of non-functioning machines, etc. should be kept in mind. SACS and DAPCU officials whenever visiting an industrial setting, as quality control measure, should visit condom outlets and verify availability, visibility and accessibility of condoms. In the case of absence of SMO in the district, agency may take up social marketing by linking up with distributers, stockists.

16.4 Monitoring and Reporting

- SMO will be responsible for maintaining CVMs and serving outlets nearby industries
- SMO will be responsible for collecting data from outlets and CVMs to report to nodal officers, who in turn will report data in monthly format to SACS

16.5 Roles and Responsibilities

Key Activities	Role of Industry	Role of SACS/TSU	Role of SMO
Access to condoms nearby industries	• Facilitate establishing CVM inside industry at places accessible to informal workers • Facilitate CSM outlets nearby industries through linkages with SMOs • Contribute resources for CVM and CSM activities • Increase access of condoms at clinics, health facilities	• Facilitate availability of condoms • Facilitate Coordination with SMO	• Coordinate with SACS and industries to establish CVM at identified spots within the industries • Provide services for refilling of CVM activities as required • Coordinate with SACS and industries to establish CSM atnon-traditional outlets nearby industries

Mentoring and Support Visits

17

SECTION

17.1 Introduction

Training of senior management, formation of coordination committee and creating a cadre of master trainers and at industry are steps towards building a company's capacity to have a sustainable HIV/AIDS intervention programme. However, to carry out these activities efficiently, it is necessary that the coordination committee and Nodal officer are provided ongoing support. It is proposed that monthly support visits to the employer-led industry site be made at least for the first six months, so that maximum reach is achieved while the training programmes are still fresh in the minds of the company and trainees.

Objective of Support Visit

- Meet nodal person and trained volenteers to clear doubts on HIV/AIDS as well as implimentation of ELM
- Meet coordination committee and assess monthly progress and follow up on process of HIV/AIDS workplace policy

17.2 Process of Support Visit

- Emphasize importance of support visits from first interaction with the company so that it is considered as a necessary part of the programme
- One can either decide fixed date for support visit or one can decide next date on every support visit
- Support visits should not last more than two hours as it could be perceived as encroaching on company time
- Call up the company two days prior to support visit, confirm timings and schedule of meetings with nodal person and coordination committee chairperson
- Meeting with nodal person: Collect monthly data and clear doubts, if any
- Meeting with trained volenteers: Not all trained volenteers might be able to attend the meeting. During this meeting, they could be asked if they came across any questions they could not answer, new and interesting questions they have come across, experiences that are worth mentioning, difficulties in reaching out to employees and how they overcame them
- Meeting with coordination committee: It would be ideal to meet all members of coordination committee, but at times it may not be possible. In such cases, meet only the chairperson. Share success stories or try to get answers to concerns. Discuss HIV/AIDS policy and hand over draft policies and policies developed by other companies

It would be ideal to meet all members of coordination committee, but at times it may not be possible. In such cases, meet only the chairperson. Share success stories or try to get answers to concerns

Please refer to Annexure 22 on checklist for mentoring and support visit.

Reporting and Documentation

18
SECTION

18.1 Measuring Results from ELM at Industry level

Measuring results is key for any indicator who understand whether the intervention is in the desired direction, to assess the effect of intervention and to ensure accountability. At the industry level, following steps can be taken for measuring results from employer-led activities

- **Data on outreach awareness and services:** Monthly reports from staff conducting awareness activities and health services are expected to be compiled by the nodal person as monthly reports. This data can be analysed to assess key indicators such as number of informal workers reached with awareness activities, number of informal workers reach through STI, ICTC services.

  SACS/TSU will support industries in analysing data and addressing challenges, if any, for further improvements during mentoring and support visits

- **Knowledge, attitude, behaviour and practices (KABP) survey:** KABP is a good tool in terms of assessing effect of ELM activities on target population i.e. informal workers. The industry can decide to conduct KABP surveys on periodic basis (once-a-year) to see effect of activities on beneficiaries in terms of change in knowledge, attitude, behaviour and practices. This will also provide opportunity to do any mid-course corrections in strategies at industry level

  SACS/TSU will support industries in conducting KABP surveys. Industries are expected to contribute resources for conducting surveys.

Monthly reports from staff conducting awareness activities and health services are expected to be compiled by the nodal person as monthly reports.

- **Referral tracking and referral linkages:** In case the industries do not have health facilities, referral linkages will be established with government health facilities for health services. The referral tracking mechanism will be established at the government ICTC, PPTCT, ART, care support centres to track referrals from industries using referral cards. SACS will ensure that referrals from industries are tracked at the government ICTC, PPTCT, ART, care and support centres. The tracking data will be analysed by SACS and feedback will be provided to industries to assess results on key indicators such as number of workers accessing ICTC services, no. of workers on ART, etc

18.2 Reporting Format:

- Industries are proposed to report on employer-led interventions on monthly basis
- SACS will provide user id and password to the industries for monthly reporting in SIMS
- Reporting format for monthly reporting is included in Annexure 19
- Nodal officer in industry will be responsible for reporting on employer-led intervention. S/He will collate reports from other department and services and send across compiled report to SACS/DAPCU
- Data and monitoring supervision flowcharts are included in **Annexure 21**

18.3 Measuring results from ELM: The following steps are suggested at SACS, district or industry level.

- Periodic reporting and feedback mechanisms
- Developing management information system
- Periodic review mechanisms at various levels
- Periodic monitoring visits to units/districts/states
- Concurrent and terminal evaluations
- Periodic sample surveys and rapid assessments

Some key indicators which can be tracked at industry level are included in Annexure 23.

18.4 Documentation

It is important to document the programme experience at various levels as these could help other employers/SACS/DAPCU officials to adopt innovative ways and practices employed by fellow employers/officials. Often this helps in not reinventing the wheel and saves up substantial time and resources. Sharing challenges and experiences among fellow employers/colleagues will help garner support and exchange of solutions. Developing case studies, best practices, programme briefs, etc., at each level, need to be encouraged and effort should be made to disseminate lessons learnt through periodic learning events.

18.5 Systems for Rewarding and Appreciating Industries that are Part of ELM

The following steps are proposed for motivating industries which are willing to implement ELM and take up employer-led interventions:

- Recognition of industries on platforms and fora at state level through key personalities at state level, appreciating their work and contribution may be part of mainstreaming activities
- Appreciating work of industries through print media such as newspapers, industry level newsletters, magazines and newsletters of state ministries, concerning industries, DAC/SACS and magazines
- Creating opportunities, platforms for representation of industry work at state, national and international levels

Annexures

19

SECTION

Annexure 1: Case Studies of interventions for addressing HIV/AIDS in the world of work

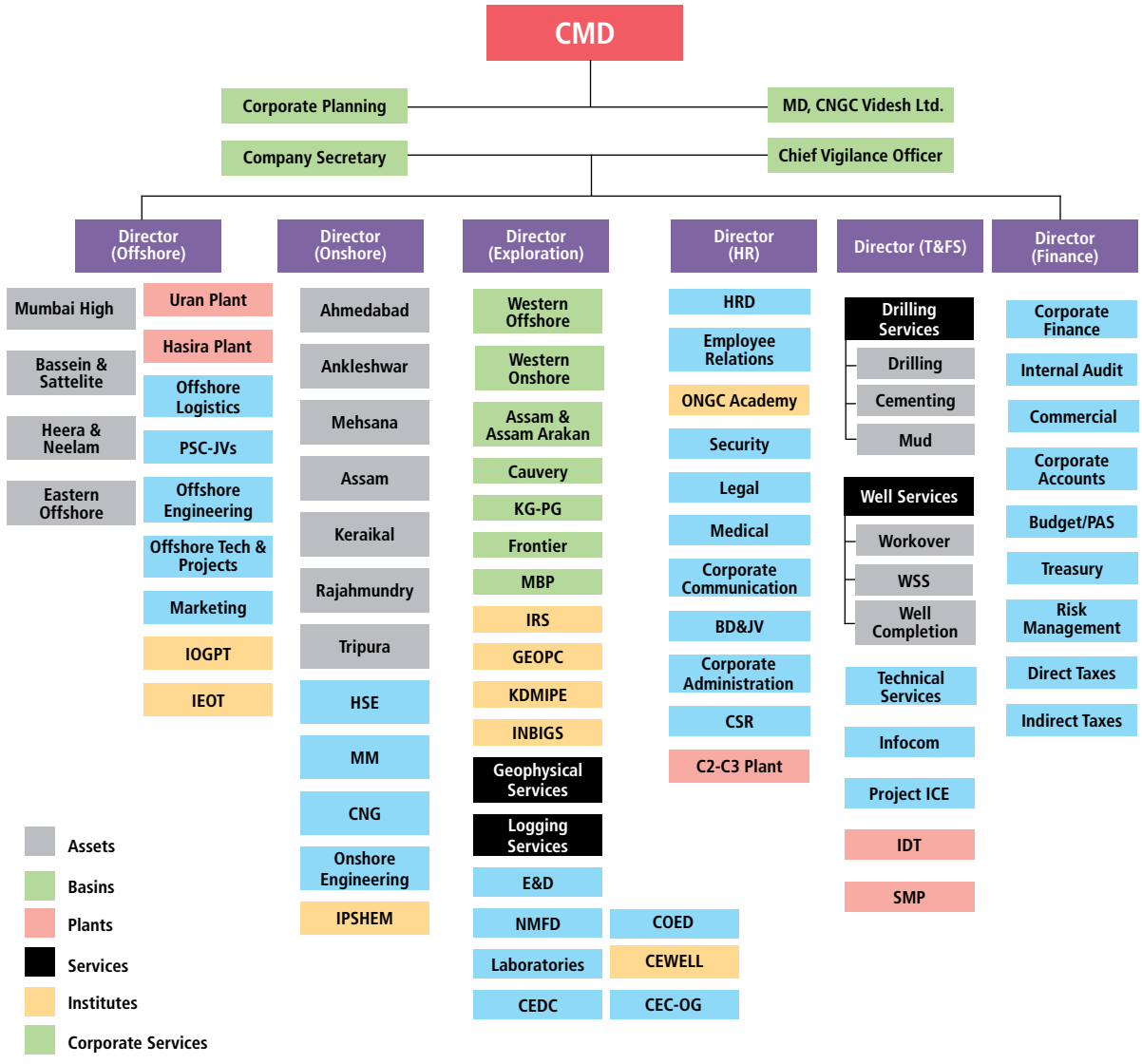
Name and Type of Industry	Key Areas of Intervention	Beneficiaries	Key Achievements	Intervention Implemented By
Organized Sector				
Reliance Industries Ltd (Petrochemicals, textiles and others) (Hazira, Gujarat)	• Awareness activities through master trainers and peer educators • HIV care and treatment through industry-linked hospital • HIV testing services	• Formal workers • Contract workers • Migrant informal workers • Local community • Local enterprises	• Overall, 260 peer educators trained • More than 750 PLHIV receiving ART from Hazira center • More than 3500 workers reached with HIV/AIDS awareness activities	The interventions begin with support from ILO. Later on, taken over by the industry
DCM Shriram Limited (Agribusiness, chemicals, plastics) (Kota, Rajasthan)	• Prevention activities • ICTC services • HIV care and treatment through industry-linked hospital	• Formal employees • Contract workers • Local community • Truckers	• More than 2000 formal and informal workers reached with HIV/AIDS prevention activities	The interventions begin with support from ILO. Later on, taken over by the industry
Ambuja Cements Limited (Cement Industries) (Ropar,Punjab) (Chandrapur, Panvel-Maharashtra) (Intervention at Roorkee, Uttarakhand)	• HIV/AIDS awareness activities through peer educators and master trainers • STI, ICTC and ART services for contract workers and truckers • Livelihood training and support to PLHIV	• Contract workers • Truckers • Local community • Messons • Supply chain industries	• More than 150 master trainers and peer educators trained across plant locations in India • More than 5000 informal workers and truckers reached with HIV/AIDS prevention activities	The interventions begin with support from ILO. Later on, taken over by the industry

Name and Type of Industry	Key Areas of Intervention	Beneficiaries	Key Achievements	Intervention Implemented By
Apollo Tyres Limited (Tyre Company) (Across India)	• HIV awareness programme for employees • 22 STI clinics at strategic trucking hubs across India • Included HIV in the code of ethics as criteria for selection of supply chain companies • Training of 4500 dealers in HIV/AIDS to reach vulnerable population • Reaching supply chain industries with HIV/AIDS programmes	• Contract workers • Truckers • Supply chain workers • Small and medium enterprises • Dealers and sales force	• 15 supply chain companies covered • 3500 supply chain workers reached • Reached 80,000 truckers • 12,000 cases of STI treated and 5000 tested for HIV, since 2009	• The interventions begin with support from ILO. Later on, taken over by the industry
Crompton Greaves Ltd (Electrical products) (22 locations across India)	• Training of employee volunteers as master trainers • Awareness activities with supply chain industries and contract workers • STI and HIV/AIDS services provided to contract workers	• Formal workers • Contract workers • Supply chain industries • Truckers and helpers	• 2000 supply chain workers reached across different units	• The interventions begin with support from ILO. Later on, taken over by the industry
Jubilant Organosys Ltd (Pharmaceutical Company) (Gajrola-Uttar Pradesh, Nanjangud-Karnataka)	• Provision of ICTC and STI services through industry linked health facility • HIV/AIDS awareness programme integrated in health and safety activities	• Contract workers • Formal workers • Truckers	• 1000 employees have taken HIV tests • 5000 workers reached through awareness activities	• The interventions begin with support from ILO later on taken over by the industry

Name and Type of Industry	Key Areas of Intervention	Beneficiaries	Key Achievements	Intervention Implemented By
TATA Power	• HIV/AIDS awareness activities through employee volunteers • HIV/AIDS awareness outside the company premises with high risk and vulnerable population • Linking up for HIV/AIDS/STI services	• Contract workers • Truckers • Migrants • Clients of sex workers • Commercial sex workers	• Reached more than 30,000 informal workers through Naka interventions • Reached more than 8000 truckers through interventions in truckers' hub • 2000 clients referred for ICTC	• The industry took lead in initiating intervention
Public Sector Units (PSUs)				
Coal India Limited	• HIV/AIDS awareness through peers covering employees and families • Set up 13 ICTCs in CCL hospitals (PPP Model) in 2009	• Formal workers • Contract workers • Truckers • Families of workers • Local community	CCL provided infrastructure and space for ICTCs, a doctor, technician and staff nurse	Intervention began with support from ILO. Later on, taken over by the industry during 2005-2007
Mumbai Port Trust	• HIV/AIDS awareness through peer educators and master trainers • ART, ICTC, STI services through the port trust hospital • HIV/AIDS policy		• 235 MbPT employees and dependents tested in ICTC per month • 7000 people utilized ICTC services during the last three years • 65 employees found positive	• Intervention began with support from ILO in collaboration with MDACS in 2005
Rashtriya Ispat Nigam Limited Visakhapatnam Steel Plant (Navratna Company) (Vishakapatnam-AP)	• Adopted HIV/AIDS policy in 2006 • HIV and TB awareness activities through master trainers and peer educators • ICTC services through hospital linked with industry	• Formal workers • Informal contract workers • Truckers	• 170 master trainers and above 2000 peer educators • Reached15,000 informal workers linked with the industry	• Initiated under Project Connect by PSI during 2006-2011

Name and Type of Industry	Key Areas of Intervention	Beneficiaries	Key Achievements	Intervention Implemented By
Bangalore Metropolitan Transport Corporation	• Adopted HIV/AIDS workplace policy • HIV and TB awareness activities	• Bus drivers • Conductors • Mechanics	• 33 senior managers were sensitized • 117 employees trained as master trainers • 1825 employees trained as peer educators • Reached 38,867 employees with messages on HIV/AIDS and TB	• Initiated under Project Connect by PSI during 2006-2011
Unorganized Sector				
Nirmaan Majdur Sanghatna (NMS) (Trade union for construction workers in Panvel, New Mumbai)	• HIV/AIDS awareness activities • Referral linkages to services • Linkages for social protection schemes for informal workers • Child-friendly centers for children of construction workers	• Workers at construction sites	• Between October 2008 and May 2009, 566 workers referred for STI • 354 workers referred for ICTC • 25 PLHIV referred for ART • Reached 40,000 workers with awareness • 80 students (children of construction workers) provided scholarships • 6000 workers provided insurance policies (LIC)	• Intervention began with support from ILO
National Trade Union Congress (INTUC) (Andhra Pradesh)	• HIV/AIDS awareness • Access to condoms • Referral linkages to STI/ICTC services	• Railway porters	• 36 peer educators identified and trained • Around 665 porters, vendors reached • 2 workers tested positive and referred to ART • 60 STI cases treated	• Intervention began with support from ILO
Delhi Metro	• HIV/AIDS awareness activities through peer educators and master trainers • Increasing access to condoms • Increasing access to HIV/AIDS prevention services	• Construction workers	• Reached 3000 construction workers at construction sites • 47 peer educators trained • 2946 condoms distributed during the intervention	• Implemented by Modicare Foundation during January-September 2005

Annexure 2: Structures of Oil and Petroleum -PSU

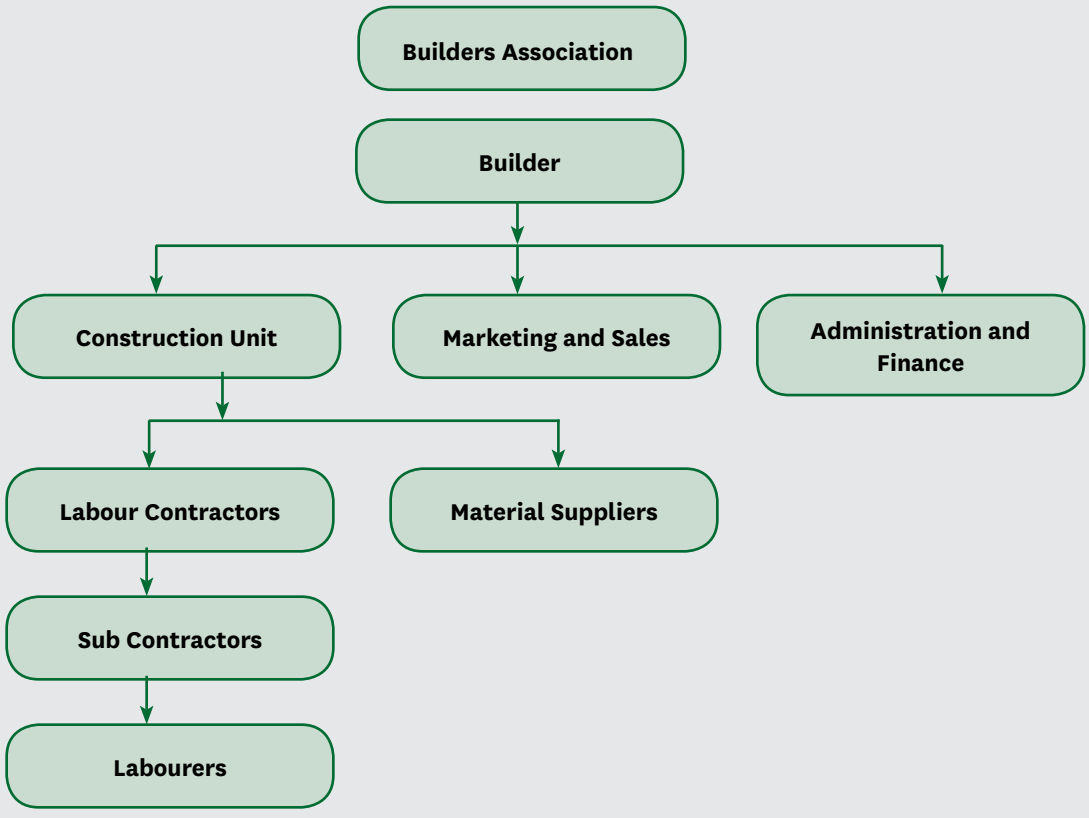


Key Actors:

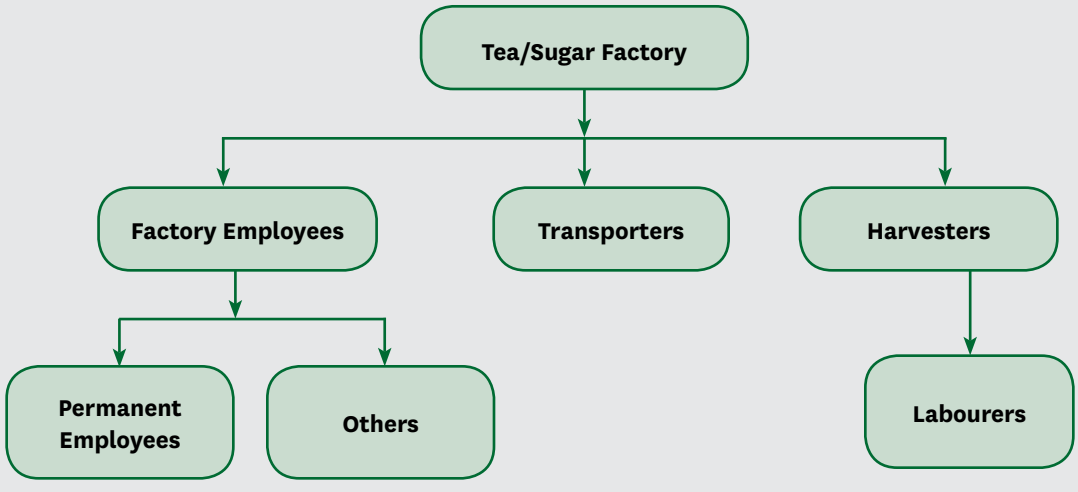
The Managing Director and Directors are the decision makers who need to be influenced for initiating interventions. The labourers are the target group and the rest could be facilitators. Among the facilitators, HR and Welfare Department, CSR department and contractors have crucial roles to play as structures that can influence the target group.

Examples of Structure of Unorganized Sector

- **Construction Sector**



Tea/Sugar Plantation-Indicative structure of plantation sector is presented below:

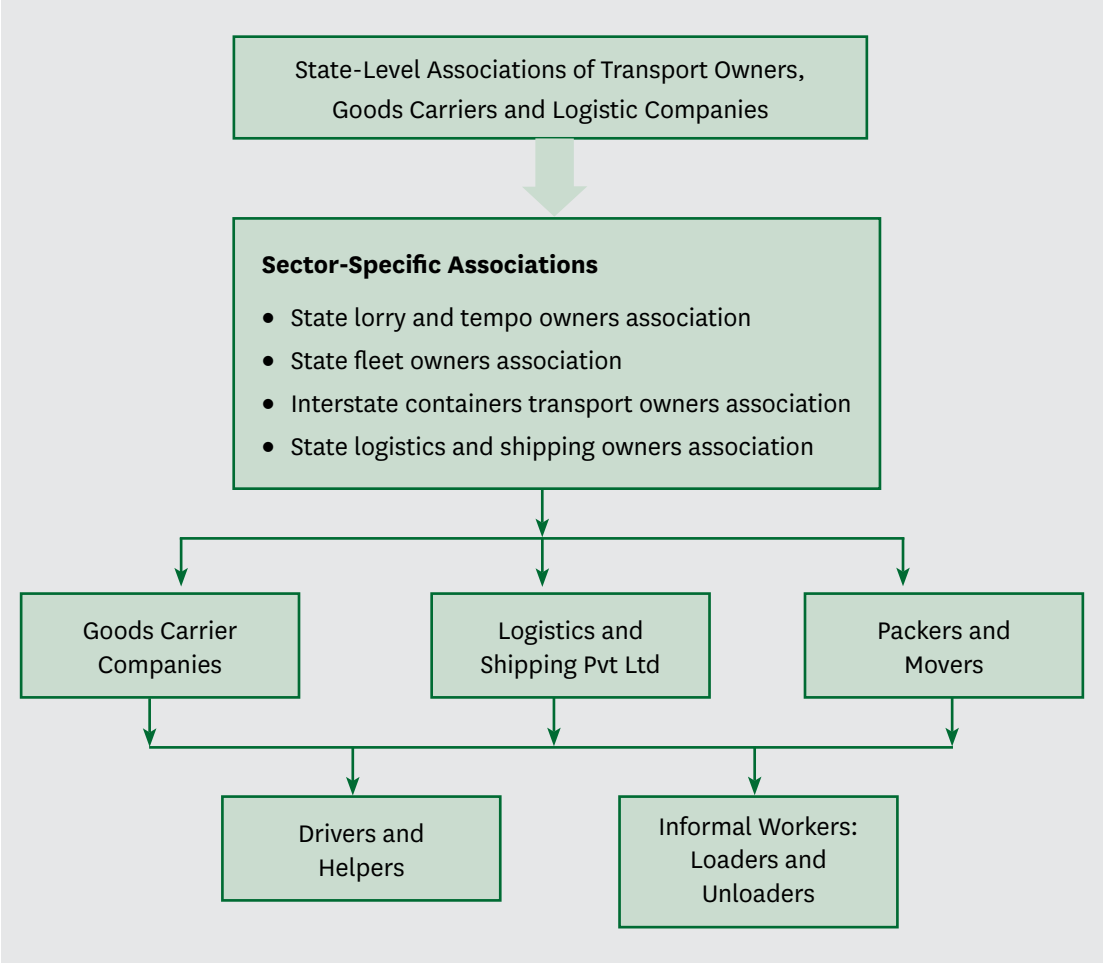


Key Actors:

As an example, in the construction sector, the builder is the decision maker. Labour forms the target group. In the case of sugarcane/plantation, harvesters and transporters form the target group and the factory owner/management is the decision-making body to be influenced.

Logistic, Goods Carrier and Transport Sector

The logistics, goods carrier and transport sector in India has multiple stakeholders. This includes transportation, packaging, storage and handling methods, and information flow. The following flow diagram enumerates some stakeholders. There could be variations across the states and type of industry. Some of these stakeholders can be tapped for intervention with truckers and informal workers as per Employer Led Model (ELM) guidelines. The typical TI-Trucker Intervention targets truckers directly and there is minimal involvement of systems and structures such as associations, federations, societies and transport owners except for the purpose of advocacy. . According to the principle of ELM, it is envisaged that wherever possible, these structures in logistics, goods carrier companies can be leveraged for reaching out to truckers, informal workers who are not covered under the TI-Truckers Intervention.



Key Actors:

In this example, state-level and sector-specific associations can be engaged for reaching out to individual owners. Owners of individual transport and logistics companies can be engaged as employers for facilitating ELM, as their business depends upon the drivers and the informal workers. Apart from these, there are examples of federations and societies working for welfare of drivers which also can be engaged for facilitating ELM. This way it will be helpful to reach truckers, informal workers who are not tapped under current TI models.

Annexure 3: Detailed Costing for Different Service Packages of ELM

Services Proposed: ART / ART + OI / ART + CD4 Testing

Scenario

- Industry/Company with 10,000 employees
- Company has its own hospital and willing to offer ART Services

Assumptions			Services	Cost Implications
Infrastructure	**HR**	**Prevalence and Disease Burden**		
Existing infrastructure to be utilized for ART centre	Existing medical doctor to be trained for managing ART services (No extra cost for doctor)	Applying 1% HIV prevalence, total HIV positive cases estimated at 100	**Only ART (INR 26.4 lakhs)** ART cost @ INR 2200 per patient per month (market rate*) for 100 cases (* Av cost of ZNL, TNL, ZNE, TNE regimen for first line is INR 2200/- pm as per market rate of these drugs...excel sheet of analysis attached) CD4 testing from govt. facilities	INR 26.4 lakhs
	Existing staff nurse to be trained for managing ART centre	OI treatment is 1 episode per patient per year (TB is most common (47%), followed by Cryptosporidiosis (43%))	**ART + OI management (INR 30.4 lakhs)** ART @ INR 2200 pm per patient per month (market rate) OI @ INR 4000 per patient per year for 100 cases CD4 testing from govt. facilities	INR 26.4 lakhs INR 4.0 lakhs
Assuming that the industry-linked health facility has a laboratory and a lab technician	Existing lab technician to be trained for providing testing services		**ART + CD4 testing (INR 27.4 lakhs)** ART @ INR 2200pm per patient per month (market rate) CD4 testing outsourced @ INR 1000 per patient per year	INR 26.4 lakhs INR 1 lakhs
Inputs from SACS: • Training of staff, maintenance of quality norms by ensuring adherence to NACP protocols of confidentiality, quality of treatment regimens				

Services Proposed: STI/RTI Treatment and OI Management, or Only STI/RTI Treatment

Scenario:

- Industry/Company with 5000 employees
- Treatment and lab facilities within existing structure

Assumptions			Services	Cost Implications
Infrastructure	**HR**	**Prevalence and Disease Burden**		
Existing infrastructure of health facility/ mobile medical units to be utilized	Existing medical doctor to be trained for Syndromic Management	Applying 6% STI prevalence among general population and same applies to the workers. Total STI cases estimated at 300 per year OI treatment is 1 episode per patient per year (TB is most common, followed by Cryptosporidiosis) RPR Testing for 300 cases per annum	**Only STI treatment (INR 1.8 lakhs)** STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (Average cost of STI syndromic treatment basis analysis of STI drug cost as per market rate....Excel sheet attached) RPR testing from govt. facilities	INR 1.8 lakhs
	Existing staff nurse to be trained for counselling and communication sessions		**STI + OI management (INR 5.8 lakhs)** STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (market rate) OI @ INR 4000 per patient per year RPR testing from govt. facilities	INR 1.8 lakhs INR 4lakhs
Assuming that industry-linked health facility has a laboratory and lab technician	Existing lab technician to be trained for providing testing services		**STI management plus RPR testing (Rs.1.87 lakhs)** STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (market rate) RPR testing @ INR 25 per patient per year for 300 cases (Test kits @ INR 15 (market price) Consumable @ INR 10 per test	INR 1.8 lakhs INR 7,500
Inputs from SACS: • Training of staff • Maintenance of quality norms by ensuring adherence to NACP protocols of confidentiality, quality of treatment regimens • IEC materials for demand generation				

Services Proposed: STI/RTI Treatment, OI Management Plus HIV Testing Services, or Only STI/RTI Treatment Plus HIV Testing Services

Scenario:

- Industry/company with 5000 employees
- Treatment and lab facilities within the existing structure

Assumptions			Services	Cost Implication
Infrastructure	**HR**	**Prevalence &Disease Burden**		
Existing infrastructure of the health facility/ mobile medical units to be utilized	Existing medical doctor to be trained for Syndromic Management	Applying 6% STI prevalence among general population. The same applies to the workers. Total STI cases estimated at 300 per year OI treatment is 1 episode per patient per year (TB is most common, followed by Cryptosporidiasis) RPR Testing for 300 cases per annum	**Only STI treatment (INR 1.8 lakhs)** STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (market rate) RPR testing from govt. facilities	INR 1.8 lakhs
	Existing staff nurse to be trained for counselling and communication sessions		**STI + OI management (INR 5.8 lakhs)** STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (market rate) OI @ INR 4000 per patient per year RPR testing from govt. facilities	INR 1.8 lakhs INR 4lakhs
Assuming that the industry-linked health facility has a laboratory and lab technician	Existing lab technician to be trained for providing testing services		**STI management plus HIV and RPR testing (Rs. 3.04 lakhs)** STI treatment for 300 cases @ INR Rs.300 per patient per episode for 12 months (market rate) RPR testing @ INR 25 per patient per year for 300 cases (as per annual 6% prevalence) Test kits @INR 15 (market price) Consumable @ INR 10 per test **HIV testing: Options for procurement of test kits and quality assurance** • HIV testing @ INR 90 per patient per year, assuming 20% of the universe would undergo testing plus all STI cases. 1300 cases per annum. Including cost of quality assurance (Test Kits supplied through vendors possessing certification of quality assurance, as per DAC guidelines)	INR 1.8 lakhs INR 7500 INR 1.17 lakhs
Inputs from SACS: • Training of staff and IEC materials for demand generation, maintenance of quality norms by ensuring adherence to NACP protocols of confidentiality, quality of treatment regimen				

Services Proposed: STI/RTI Treatment Plus Outreach Services

Scenario:

- Industry/company with 5000 employees
- Treatment and lab facilities within existing structure

<table>
<tr><th colspan="3">Assumptions</th><th rowspan="2">Services</th><th rowspan="2">Cost Implication</th></tr>
<tr><th>Infrastructure</th><th>HR</th><th>Prevalence and Disease Burden</th></tr>
<tr><td>Existing infrastructure of health facility/ mobile medical units to be utilized</td><td>Existing medical doctor to be trained for Syndromic Management</td><td rowspan="3">Applying 6% STI prevalence among general population and same applies to the workers. Total STI cases estimated @ 300

Outreach sessions conducted at least 10 times in a month and reaching out to 150 subjects per month</td><td>Only STI treatment (INR 1.8 lakhs)
STI treatment for 300 cases @ INR 300 per patient per episode for 12 months (market rate)

RPR testing from govt. facilities</td><td>INR 1.8 lakhs</td></tr>
<tr><td></td><td>Existing staff nurse to be trained for counselling and communication sessions</td><td>STI management plus outreach sessions (INR 4.1 lakhs)

STI treatment for 300 cases @ INR300 per patient per episode for 12 months (market rate)

Outreach materials@ INR60 per person per year for 3000 subjects

Training cost for staff on outreach communication sessions per year</td><td>INR 1.8 lakhs

INR 1.8 lakhs

INR 50,000</td></tr>
<tr><td></td><td>Existing supervisors/ HR managers/ Health officers to be oriented on group communication sessions</td><td>Only outreach sessions (INR 2.3 lakhs)

Outreach materials @ INR 60 per person per year for 3000 subjects

Training cost for staff on outreach communication sessions per year</td><td>INR 1.8 lakhs

INR 50,000</td></tr>
<tr><td colspan="5">Inputs from SACS:
• Training of staff and IEC materials for demand generation
• Maintenance of quality norms by ensuring adherence to NACP protocols of confidentiality, quality of treatment regimen</td></tr>
</table>

STI/RTI treatment, Outreach Awareness in Industry Without Health Facility

Scenario:

- Industry/company with 5000 employees
- Industry/company lacks own health facility

Assumptions			Services	Cost Implication
Infrastructure	**HR**	**Disease Burden**		
	Existing medical doctor to be trained for syndromic Management	Applying 6% STI prevalence among general population and same applies to the workers, total STI cases estimated 300 Outreach sessions conducted at least 10 times in a month and reaching out to 150 persons per month	**Only STI treatment (INR 2.28 lakhs)** STI treatment for 300 cases @ Rs. 300/- per patient per episode for 12 months (market rate)	1.8 lakhs
			Medical doctor charges for part time once in fortnight @ 2000 per day	48,000
Existing infrastructure of the health facility/ mobile medical units to be utilized	Existing staff nurse to be trained for conseling and communication sessions		**STI management plus outrach sessions (INR 4.1 lakhs)** STI treatment for 300 cases @ Rs. 300/- per patient per episode for 12 months (market rate)	1.8 lakhs
			Outreach materials @ Rs. 60/- per person per year for 3000 persons	1.8 lakhs
			Training cost for staffs on outreach communication sessions per year	50,000
	Existing supervisors/ HR managers/Health officers would be oriented on group communication sessions		**Only outreach sessions (INR 2.3 lakhs)** Outreach materials @ Rs. 60/- per person per year for 3000 persons	1.8 lakhs
			Training cost for staffs on outreach communication sessions per year	50,000

Services Proposed: STI/RTI Treatment Plus Outreach Services

Scenario:

- Industry/Company with 1000 employees
- Lacks health facility

Assumptions			Services	Cost Implication
Infrastructure	**HR**	**Prevalence and Disease Burden**		
Supervisors/ contractors/ employee volunteers to be trained for awareness. Allopathic doctor to be hired for on-site camps on monthly basis	Hired medical doctor to be trained for Syndromic Management	Applying 6% STI prevalence among general population and same applies to the workers. Total STI cases estimated @ 60 cases a year Outreach sessions conducted at least 10 times in a month and reaching 150 persons per month	**Only STI Treatment (INR 114,000)** STI treatment for 60 cases @ INR 300 per patient per episode for 12 months (market rate)	INR 36,000
			General medicines for health camps @ INR 30,000 per year lump sum cost	INR 30,000
			Charges of hired medical doctor for health camps once in a fortnight @ INR 2000 per day for four hours each day	INR 48,000
			RPR testing from govt. facilities	
			STI Management Plus Outreach Sessions (INR 194,000) STI treatment for 60 cases @ INR 300per patient per episode for 12 months (market rate)	INR 36,000
			General medicines for the health camps @ INR 30,000 per year lump sum cost	INR 30,000
			Charges of hired medical doctor for health camps once in a fortnight @ INR 2000 per day for four hours each day	INR 48,000
			Outreach materials @ INR 60 per person per year for 1000 people	INR 60,000
			Training cost for staff on outreach communication sessions per year	INR 20,000
	Existing supervisors/ HR managers/ health officers to be oriented on group communication sessions		**Only Outreach Sessions (INR 80,000 lakhs)** Outreach materials @ INR 60 per person per year for 1000 people	INR 60,000
			Training cost for staff on outreach communication sessions per year	INR 20,000

Services Proposed: STI/RTI Treatment Plus Outreach Services

Scenario:

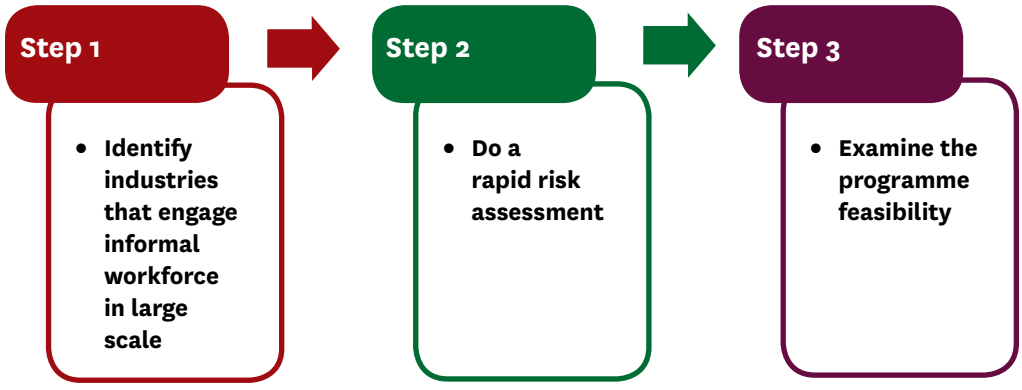
- Industry/Company with 500 employees
- Lacks health facility

Assumptions			Services	Cost Implication
Infrastructure	**HR**	**Prevalence and Disease Burden**		
Supervisors/ Contractors/ Employee volunteers to be trained for awareness. Allopathic doctor to be hired for on-site camps on month basis	Hired medical doctor to be trained for Syndromic Management	Applying 6% STI prevalence among general population and same applies to the workers. Total STI cases estimated at 30 a year Outreach sessions conducted at least 10 times in a month and reaching 150 people per month	Only STI Treatment (INR 81,000) STI treatment for 30 cases @ INR300 per patient per episode for 12 months (market rate)	INR 18,000
			General medicines for the health camps @ INR 15,000 per year lump sum cost	INR 15,000
			Charges of hired medical doctor for health camps once in a fortnight @ INR 2000 per day for four hours each day	
			RPR testing from government facilities	INR 48,000
			STI management plus outreach sessions (INR 121,000)	
			STI treatment for 30 cases @ INR 300 per patient per episode for 12 months (market rate)	INR 18,000
			General medicines for health camps @ INR 30,000 per year lump sum cost	INR 15,000
			Charges of hired medical doctor for health camps once in a fortnight (@ 2000 per day for four hours each day)	INR 48,000
			Outreach materials @ INR 60 per person per year for 500 people	INR 30,000
			Training cost for staff on outreach communication sessions per year	INR 15,000
	Existing Supervisors/ HR Managers/ Health Officers to be oriented on group communication sessions		**Only outreach sessions (INR 45,000)**	
			Outreach materials @ INR 60 per person per year for 1000 people	INR 30,000
			Training cost for staff on outreach communication sessions per year	INR 15,000

Approximate cost of different packages under ELM:

Services	Number of beneficiaries per year	Total cost per year	Unit cost per person per year
Only Outreach Sessions	500	INR 45,000	INR 90
Outreach + STI management	500 (30 STI cases+500)	INR 121,000	INR 228
Only STI management	500 (30 STI cases+500 General health	INR 81,000	INR 152
Only outreach Sessions	1000	INR 80,000	INR 80
Outreach + STI management	1000 (60 STI cases+1000)	INR 194,000	INR 183
Only STI Management	1000 (60 STI cases+1000 general health)	INR 114,000	INR 114
Only outreach sessions	3000	INR 230,000	INR 77
Outreach + STI management	3300 (300 STI cases+3000 others)	INR 410,000	INR 124
STI management	300 cases	INR 180,000	INR 600
STI + OI management	400 (300 STI cases + 100 PLHA)	INR 580,000	INR 1450
STI management plus HIV and RPR testing	1300 (300 STI cases + 1000 others)	INR 6.1 lakhs	INR 469
HIV testing	1000	INR 1.17 lakhs	INR 117
Only ART Services	100	INR 26.4 lakhs	INR 26,400
ART plus OI management `	100	INR 30.4 lakhs	INR 30,400
ART plus CD 4 testing outsourced	100	INR 27.4 lakhs	INR 27,400

Annexure 4: Steps in Identifying and Prioritising Industries for ELM



Example of Prioritization

Example 1: Methodology employed for identifying and prioritizing economic sectors in coastal Andhra Pradesh for focused HIV/AIDS interventions with industries (Source: PSI, 2009)

Step	Activity	Method	Instrument	Outcome
1	Enumeration of economic sectors in coastal AP	Desk review, Key Informant Interviews (KII)	KII guide, checklist	Economic sectors in coastal AP enumerated
2	Short-listing and profiling top 20 economic sectors in coastal AP with largest blue-collar workforce	Desk review, KII	KII guide, checklist	Top 20 economic sectors in coastal AP identified and profiled
3	Identify and map top 10 Most at Risk Economic (MARE) sectors from the top 20 given above	Rapid assessment of sectors, consultative workshop of stakeholders	KII guide, checklist	Top 10 MARE sectors in coastal AP for in-depth study identified
4	Risk assessment and programme feasibility analysis	Sample survey with sample size 600 for each MARE sector, KII for feasibility analysis	Semi-structured interview schedule, KII guide, checklist for feasibility analysis	Sectors for focused intervention identified and prioritized

Example 2: Prioritization of industries for employer intervention: Checklist used for prioritizing and feasibility of ELM in one of the SACS

1	District	
2	Name of industry	
3	Sector	
4	Type of industry	
5	Name of contact person and contact number	
6	Organized sector with large number of informal workers (manufacturing industries, cement, automobile, steel, textile, paper, etc.)	
7	Unorganized sector (construction, harvesting, plantation, quarry mining, small scale industries, steel, etc.)	
8	Number of total employees in the industry	
9	Number of total migrant labourers employed	
10	Number of migrant workers in the payroll of employer	
11	Statewise split-up of migrant labourers employed directly by the company (in its pay roll)	
12	Number of migrants employed in the industry as contractors (not in the company's payroll)	
13	Nature of work given on contract/outsource and number of contractors engaged	
14	Whether the migrant workers changes frequently (under a contractor)	
15	Whether health facility exists within the industry	
16	What is the alternative health care facility (if the industry does not have own facility) for the workers (on call doctor/private hospital linkage)	
17	Any programmes undertaken for the prevention and care and support of HIV	
18	Enlist current CSR Activities	
19	Have you identified health issues among migrant labourers	
20	Any other additional information	
21	Whether the industry is willing to associate with the govt/ to provide HIV prevention services to migrant labourers	

Annexure 5: Industrywise Suggested Framework of Activities, Roles and Responsibilities for ELM

Key Activities	Role of DAC	Role of SACS/TSU/DAPCU**	Role of PIPPSE (till 2017)	Role of Employer
Pre-Roll Out Phase				
Developing operational guidelines, training manuals, tools for ELM	• Finalize and approve Operational Guidelines, training manuals, tools, monitoring plan etc. for ELM		• Develop – Operational guidelines – Training manuals – Monitoring plan – Communication tools etc. for ELM	
Management structure and human resources identified for facilitating ELM at field level	• Identify existing human resources and management structure for facilitating ELM at SACS/TSU and DAPCU level		• Identify panel of trainers, experts for providing training, technical support to SACS/TSU • Identify pool of regional resources for ongoing technical support to SACS/TSU for facilitating ELM	
Training of Trainers (TOT) from SACS/TSU on ELM model to build capacities for facilitating ELM	• Identify human resources to be trained from SACS/TSU • Direct identified SACS/TSU officials to attend TOTs • Finalize and approve training plan	• Target audience for TOT – TI Division – TSU Team Leader/TSU-TL-TI – M&E person – Mainstreaming division	• Develop training plan for TOTs at national/regional and state level and share with DAC • Support DAC in conducting TOTs at national/regional and state level with the help of identified pool of trainers and consultants	

Roll Out of ELM at Field Level				
Training of identified DAPCU, SACS, TSU officials at state level	• Finalize and approve training plan	• Target Audience: DAPCU, SACS officials from BSD, CST, STI, M&E, mainstreaming division • Develop training plan for state-level training • Identify human resources to be trained at the DAPCU and other related SACS/TSU departments • Conduct training of DAPCU, other related SACS/TSU officers in ELM	• Technical support for training through identified resource persons • Hand holding of SACS for conducting trainings at state level • Provide update and training reports to DAC	
Mapping and prioritizing industries at state level for implementation of ELM	• Finalize and approve tools for mapping and prioritizing industries for ELM	• Collate data on industries from secondary sources • Vulnerability assessment through key informant interviews and informal workers interviews • Profiling of clients and ICTC data for assessing migrant risk groups	• Develop formats, tools for mapping and prioritizing industries at state level • Hand holding of SACS/TSU for mapping and prioritizing industries at state level • Build capacities of SACS for conducting mapping and prioritizing industries	
Advocacy with Employers' Associations for reaching out to industries for ELM	• Advocacy with Employers' Associations such as CII, FICCI, ASSOCHAMat National level • Finalize role of Employers' associations in supporting ELM at national and state level	• Advocacy with state chapters of Employers' associations with an objective to reach prioritized sectoral industries for ELM	• Support DAC, SACS on developing materials, tools for advocacy with employers' associations • Hand holding SACS/TSU at state level for conducting advocacy meetings	• Employers association to facilitate the meeting with member employers

Approaching prioritized industries, making the first contact	• Finalize and approve tools, presentation and share with SACS	• Establish initial contacts with prioritized industries as per guidelines • Making pitch for ELM to the industry • Follow up with prioritized industries	• Develop tools for pitch presentation with industries, approach industries and share with DAC • Provide technical support to SACS at state level	• Employers to contribute time and resources for meetings at industry level • Support to identify systems and structures at industries
Sensitizing gatekeepers	• Finalize and approve tools for sensitizing gatekeepers and share with SACS	• Identify gatekeepers at industries • Conduct gatekeepers' sensitization programme with identified gatekeepers at industry level	• Develop gatekeepers sensitization module, tools, presentations • Build capacities of SACS/ TSU/DAPCU for facilitating sensitization • Provide technical support as required at state level for conducting gatekeepers' sensitization	• Organize gatekeepers' sensitization • Contribute resources for conducting gatekeepers' sensitization
Key Activities	**Role of DAC**	**Role of SACS/TSU/DAPCU****	**Role of PIPPSE**	**Role of Employer**
Identify existing structures and systems within industry and facilitate developing proposal for ELM	• Finalize sample proposal formats and share with SACS/TSU	• Facilitate identifying existing structures and systems at industry level • Facilitate proposal for ELM at industry level by integrating HIV/ AIDS programme within existing systems and structures	• Develop sample proposal formats, strengthen capacity of SACS/TSU and DAPCU • Ongoing technical support to SACS/TSU for facilitating proposals	• Work with SACS/TSU representative for developing industry specific proposal for ELM • Identify existing systems and structures within industries

Identifying nodal person from industry and establishing coordination committee at industry level	• Finalize and approve TOR, guidelines for nodal person and coordination committee	• Facilitate identification of nodal person at industry level • Facilitate establishing coordination committee at industry level	• Develop TOR for coordination committee and nodal person • Build capacities of SACS/TSU in facilitating coordination committee	• Identify nodal person from industries • Establish coordination committee at industry level with support from SACS • Ensure systems for confidentiality and stigma-free environment are established
Facilitate adoption of workplace HIV/AIDS policy	• Facilitate linkages of SACS with DOL at state level for supporting SACS to create linkages with industries that wish to adopt HIV/AIDS workplace policy	• Facilitate linkages with DOL at state level for adopting national workplace policy on HIV/AIDS • Options could be integrating the policy in the existing health/safety policy or adopting separate HIV/AIDS policy	• Brief SACS/TSU officials on the national workplace policy on HIV/AIDS • Orient on referral mechanism and role of labour department in facilitating adoption of HIV/AIDS policy	• Adopt and integrate national HIV/AIDS policy

Key Activities	Role of DAC	Role of SACS/TSU/DAPCU**	Role of PIPPSE	Role of Employer
Awareness and demand creation of HIV/AIDS prevention, services and condoms Existing medical and para- medical staff can be trained in conducting awareness sessions • Supervisors can be trained in conducting awareness sessions • Employee volunteers from industries can be trained as peer leaders for conducting awareness sessions	• Finalize training manuals, communication tools, materials and share with SACS	• Facilitate training and capacity building of existing available human resources at industry level • Provide hand holding to industries for keeping trained volunteers motivated for conducting awareness activities	• Develop training manual for employee volunteers, supervisors and medical staff at industry level • Develop guidelines, tools for awareness activities • Build capacities of SACS/TSU for conducting training of peer leaders • Provide ongoing technical support to SACS/TSU for conducting trainings at industry level	• Identify human resources to be trained • Contribute time of identified employee volunteers, medical staff, supervisors for training • Contribute infrastructure for conducting trainings • Contribute resources for developing communication tools materials for ELM • Reporting of data on awareness activities with SACS • Provide resources for printing of IEC material

Integrating HIV/AIDS services within existing hospital/clinic/health care facility	• Finalize and approve guidelines for integrating HIV/AIDS services within existing health setups linked with industries	• Identify existing health facilities, clinics linked with industries • Propose integrating HIV/AIDS services within existing facilities • Conduct facility assessment in collaboration with technical services departments • Facilitate MOU signing for integrating HIV/AIDS services as per guidelines • Facilitate training of medical and para-medical staff • Facilitate establishing reporting systems	• Build capacities of SACS/TSU for integrating HIV/AIDS services within existing facilities • Develop guidelines for implementing HIV/AIDS services integrated into existing systems • Develop tools, MIS system for capturing service-related data from health services • Provide ongoing technical support to SACS/TSU for integrating HIV/AIDS services within existing health facilities	• Contribute infrastructure, medical, para-medical staff for integrating HIV/AIDS services within existing systems and structures • Identify systems and structures that can be used for integrating HIV/AIDS services • Supervise and monitor functions of health facilities and reporting of data on services delivery models • Ensure systems for confidentiality of services • Provide resources for printing of IEC material

Key Activities	Role of DAC	Role of SACS/TSU/DAPCU**	Role of PIPPSE	Role of Employer
HIV/AIDS service for industries without health facilities	• Finalize and approve guidelines for HIV/AIDS services, for industries without health facilities	• Facilitate linkages of medical doctor for conducting monthly health camps at industry level • Facilitate linkages of mobile ICTC to industry for conducting ICTC camps • Develop referral linkages to ICTC, ART in case the mobile ICTC is not feasible • Facilitate linkages with public health systems for conducting health camps at industry level	• Develop guidelines for facilitating health services for industries without permanent health facilities • Build capacities of SACS/TSU and DAPCU for implementing health camps at industries not linked with health facilities • Develop tools, MIS system, reporting formats for conducting data/information on health services linked with industries	• Coordinate with identified medical doctor for conducting health camps at industry level • Provide resources for conducting health camps, mobile ICTC camps at industry level • Ensure confidentiality of services • Ensure capturing data and reporting to SACS for health camps conducted on regular basis • Provide resources for printing of IEC, communication tools

Access to condoms nearby industries	• Finalize guidelines for condom accessibility and share with SACS/TSU • Direct all SMOs for supporting employer-led interventions in respective states	• Facilitate linkages of SMOs with industries for establishing Condom Vending Machine (CVM) and Condom Social Marketing (CSM) activities • Coordinate with nodal person and coordination committee to ensure that free condom supply is available at industry level either through clinics and health facilities within industry gates • Provide training to peer educators, supervisors and as part of HIV/AIDS training, ensure that informal workers are aware of correct and consistent use of condoms	• Develop guidelines for condoms accessibility at industry level • Develop tool, MIS system for capturing data information on condom uptake by informal workers	• Establish CVM inside the industry at a place accessible to informal workers • Facilitate CSM outlets nearby industries, through linkages with SMOs • Increase access of condoms at clinics, health facilities • Provide resources for printing IEC material
Mentoring and support visits to industries post facilitating ELM activities	• Finalize and approve guidelines for mentoring and support visit to industries	• Regular support visits to industries to oversee activities, provide hand holding to industries for implementation of ELM activities • Conduct meetings with senior management and gatekeepers to keep them updated on activities • Conduct meetings with nodal officers and coordination committee to resolve any challenges faced in implementation	• Develop tools, reporting formats for monthly mentoring and support visits • Develop guidelines for mentoring and support visits • Build capacities for SACS/TSU/ DAPCU for support visits • Ensure hand holding of SACS in initial phase of roll out	• Ensure cooperation to SACS/TSU representatives visiting industries • Ensure regular meetings of nodal person and coordination committee for smooth implementation of ELM at industry level • Ensure regular reporting of data on ELM activities to SACS

Monitoring, evaluation and documentation	• Finalize and approve MIS systems, M&E guidelines and reporting formats	• Facilitate implementation of MIS system at industry level to capture data • Facilitate monitoring and evaluation for capturing key indicators related to employer-led intervention • Conduct regular meetings with nodal person and coordination committee for resolving challenges in MIS	• Develop M&E tools, MIS systems, reporting formats • Build capacities of SACS/TSU for facilitating M&E and MIS system at industry level • Provide hand holding to SACS for conducting reviews at industry level • Design and conduct technical reviews for ELM at field level	• Submit monthly reporting formats to SACS • Ensure data with respect to awareness activities and service delivery is captured and reported to SACS • Direct nodal person and coordination committee to maintain MIS systems and reporting on regular basis

** ELM will be facilitated by SACS-TI division in collaboration with other divisions at SACS. TSU will be supporting SACS for facilitation. DAPCU units will play the role of facilitator at district level

Annexure 6

Sample Letter of Intent
(ON THE LETTER HEAD)

Date-.....

To,

The Project Director

State AIDS Control Society

LETTER OF INTENT TO INITIATE EMPLOYER LED MODEL AT (NAME OF THE COMPANY)

Dear Mr.....,

This is with reference to the project proposal and budget discussed with (name of concerned person) on (date) to initiate Employer Led Model (ELM) at our company.

We are agreeable to begin this programme and would like to implement following components of the programme:

1.....

2.....

3.....

We request for technical support on the programme from the .....State AIDS Control Society

Hope to have a meaningful association with State AIDS Control Society.

Thanking you,
Sincerely

(Name of the Person)
(Designation)

Annexure 6.1: Sample Proposal for ELM in Partnership with Industries

Introduction

The National AIDS Control Programme (NACP IV) proposes ELM to enhance coverage of vulnerable informal workers linked with industries, using existing structures and systems of the industries.

AIM

To help prospective employers develop a comprehensive programme on HIV/AIDS prevention and care by integrating HIV/AIDS programme with existing systems, structures and resources within their business and training agenda.

Objectives of ELM

- Increase awareness and access to HIV/AIDS prevention to care services for informal workers
- To create enabling environment by reducing stigma and discrimination against PLHIV
- To encourage and help prospective employers integrate and sustain the HIV and AIDS intervention programme within existing systems and structures

Areas of Collaboration

XYZ Pvt. Ltd. and the .....State AIDS Control Society agree to cooperate in the development and implementation of an ELM for reaching informal workers linked with industries with HIV/AIDS prevention to a care programme that includes four components:

Component	Goal	Main Activities	SACS Contribution	XYZ Pvt. Ltd. Contribution	Time Frame (est.)
Coordination Committee at Industry Level	To ensure company ownership and sustainability of HIV/AIDS workplace programme	– Nomination of nodal person – Formation of joint coordination committee	– Technical assistance to nodal person and committee – Facilitation of ELM through nodal officer and coordination committee	– Nomination of HIV/AIDS nodal person with TOR – Designation of HIV/AIDS committee members and TOR – Staff time allocated to nodal person to oversee HIV/AIDS activities	DATE: Nodal person named: committee established

Component	Goal	Main Activities	SACS Contribution	XYZ Pvt. Ltd. Contribution	Time Frame (est.)
Awareness and information Services	To support HIV/AIDS prevention, non-discrimination, care and support	– Senior/middle management training – Training of health facility staff, supervisors/ contractors – Incorporation of HIV/ AIDS module into regular training programmes – Ensuring condom availability at industries – Creation and regular update of information on STI, ICTC and care and support services outside workplace	– Training curriculum – Training of trainers – Mentoring support to health staff, – Provide regular update of information on STI, ICTC and care and support services around workplace	– Allocation of time of health staff, supervisors, contractors for conducting sessions – Allocation of space for activities – Incorporation of HIV/AIDS module into regular health and safety or HR training programmes – Partnership established to ensure provision of condoms to workers – Information, education and communication materials developed	Calendar for training and information services to be determined
HIV/AIDS/STI Services	Provision of HIV/ AIDS/STI services for workers either by integrating services within existing health setups or organizing health camps	– Integrate HIV/AIDS/ STI services within own health setups – In case industry does not have health facility, organize health camps – Referral linkages to ICTC, ART and care and support services	– Technical support for integrating services – Create linkages with BSD and CST division for integrating services – Technical support for organizing health camps in case of no health facility – Referral linkages for ICTC, ART services in case of no health facility	– Share infrastructure, human resources for integrating HIV/ AIDS, STI services within existing health facility – Create systems for regular health camps in case of no health facility – Provide resources for organizing health services – Provide resources for drugs/test kits for STI/ICTC services – Establishment of referral system with community ICTC and care and support services, Sputum Microscopy and DOTS services; provision of information on such services to workers	Date: (as agreed with industry senior management)

Component	Goal	Main Activities	SACS Contribution	XYZ Pvt. Ltd. Contribution	Time Frame (est.)
HIV/AIDS Policy	To establish procedures and practices for dealing with HIV/ AIDS issues in workplace	– Drafting of policy in consultation with worker representatives – Adoption and publication of policy – Briefing to explain policy to all workers – Annual review	Linkages to ministry of labour for developing HIV/AIDS policy	– Drafting of policy in consultation with HIV/AIDS Committee – Dissemination of HIV/AIDS policy – Briefings to explain HIV/AIDS policy to workers	As of DATE:
Monitoring and Evaluation	To manage project and measure results	Regular monitoring by nodal person and coordination committee	- Provide monitoring forms to nodal person; periodic verification	– Monthly monitoring by nodal person	Nodal person monitoring monthly
Mentoring and support visits by SACS	Mentoring and support visits by SACS on monthly basis in the initial phase and on quarterly basis once activities are rolled out at industry level	– SACS representatives will visit company/ industry for mentoring and support for smooth implementation of ELM	– Schedule monthly visits in the initial face and on quarterly basis once activities are rolled out at Industry level – Provide support to company/industry to address issues, bottle necks in implementation of ELM	– Allow SACS to visit and interact with concerned departments during mentoring and support visits	– Monthly visits in the initial phase and on quarterly basis once activities are rolled out at industry level

XYZ Pvt. Ltd. hereby agrees to take lead in implementing HIV/AIDS intervention in partnership with

.....State AIDS Control Society (SACS)

_____ _____

Company Representative

XYZ Pvt. Ltd

Date:

Program Director

State AIDS Control Society

Date:

* This is a general proposal which needs to be customized to the needs of industries

Annexure 7: Systems and Structures Which Could Be Leveraged for ELM

The following table describes a broad framework of systems/structures and stakeholders that could be leveraged in the organized and unorganized sector. Further, with each industrial sector within the organized and unorganized sector, the stakeholders, systems and structures that could be leveraged would differ, depending on availability. In the beginning of the intervention, a detailed mapping and assessment will identify the stakeholders, systems and structures that could be leveraged for HIV/AIDS intervention. The proposed ELM will leverage the identified stakeholders, systems and structures for implementing HIV/AIDS Intervention.

Type of Industry	Type of Employer and Stakeholder Associated	Systems Which Could Be Leveraged for Following Components of HIV/AIDS Intervention for Informal Workers	
		Awareness and Demand Creation	Service Delivery
Organized industries (manufacturing industries such as cement, steel, automobile, textile, etc. which employ vulnerable, migrant informal workers)	Employer: Company management CSR, Welfare and HR Departments State-level associations, sectoral divisions within associations.	• Comprehensive health and safety programme, trainings for integrating HIV/AIDS awareness programme • HR induction trainings, welfare programmes for integrating HIV/AIDS awareness programme • Using employee volunteers as outreach workers for creating awareness • Informal workers as peer educators • Forming street play group from among employee volunteers for Mid Media activities • Social and educational activities within companies for integrating HIV/AIDS awareness programmes • IEC material printed by company • Officer's wives' clubs for creating awareness among female informal workers • Sensitizing management to enforce supply chain vendors to adopt HIV/AIDS programme for their workers as part of contractual clause	• Existing health setups such as hospitals or clinics at plant level for integrating HIV/AIDS/STI services • Periodic on-site health camps by engaging private doctors organized by company management • Reimbursement of fixed medical cost by company for STI/HIV/AIDS ICTC services • Engaging medical department for conducting ICTC camps with support from SACS • CVM and CSM in and around the company with support from SMO

Type of Industry	Type of Employer and Stakeholder Associated	Systems Which Could Be Leveraged for Following Components of HIV/AIDS Intervention for Informal Workers	
		Awareness and Demand Creation	Service Delivery
Unorganized sector (construction, harvesting, plantation, quarry mining, etc.)	Type of employer: Builders, sugarcane factory owners, merchants, mining company owners, etc. Contractors, subcontractors, supervisors Workers trade unions Sectoral Associations/Societies/ Federations	• Using gatekeepers such as contractors/ subcontractors/trade union leaders, etc. to be master trainers • Peer educators from informal workers • Sensitizing employers/associations to make HIV/ AIDS activities mandatory as part of contractual clause with contractors • Integrating HIV/AIDS within comprehensive health and safety programme through CSR of employers/associations (e.g builders can contribute resources for construction workers programme)	• Periodic on-site health camps by engaging private doctors through resource contribution from structures such as employers/associations • Societies/Federations, etc. • Leveraging health facilities of big industries for providing services to unorganized sector wherever possible • Using structures such as rotary/lions club for providing medical services including HIV/AIDS services • Reimbursement of fixed medical cost by employer/associations for STI/HIV/AIDS ICTC services. • Referral linkages to existing public health services • CVM and CSM in and around the company with support from SMO
Medium and small-scale industries	Type of employer: Medium and small-scale industry owners Small-scale industries associations/ societies	• Using existing trainings, social platforms of small-scale industry associations for integrating HIV/AIDS activities • Creating system of master trainers from representatives of associations who can train peer educators from different units for conducting awareness programmes • Using employee volunteers from other big industries to create awareness and demand creation activities within small-scale industrial area • Training of employees from selected units to be peer educators for awareness activities	• On-site health camps by engaging private doctors using resources from small-scale industry associations/industrial area societies • Mobile ICTC services, cost reimbursed by associations/industrial area societies • Using structures such as rotary/lions club for providing medical services including HIV/AIDS services • Using health facilities of big industries in industrial areas for providing services to other industries • CSR resources mobilizing from companies whose supply chain comes from SSI

Annexure 8: Sample letter of Introduction and Pitch Presentation

Sending letters to the decision-maker in the companies

A letter elaborating the need to address HIV/AIDS issue at the workplace and introducing ELM could be drafted and sent to the decision-making person in the company.

The letter could be sent to

- Chief Executive Officer
- Managing Director
- General Manager
- Vice-President HR
- HR Head

Who should send the letter:

- Letter should be sent by PD, SACS on the letterhead

The letter also can be send to employers' associations to seek their support and subsequent meeting can be organized with decision makers at employers' associations to organize meetings with member industries. Similar letters to be sent to Employer Association, Department of Industries and Cmmerce, Department of Labour and Employment by PD, SACS.

Suggested Sample Initial Letter to Industries

Date:

Dear Mr. ,

India with its 2.1 million HIV positive people has the third highest prevalence of HIV infections in the world, following South Africa and Nigeria. 89% of HIV infections have been reported in the age group of 15-49 years -- the most economically productive group that is at the heart of your business. HIV/AIDS could impact businesses due to loss of skilled workforce, death, reduced productivity, absenteeism and ill health, thereby implying a consequent increase in recruitment and training costs.

The industrial sector in public and private, organized and unorganized sector stands vulnerable as HIV/AIDS affects the most productive age group. Whether a company operates in a low-prevalence country or a high-prevalence country, HIV/AIDS is a factor that can affect industries if the workforce linked with the industry is at risk and vulnerable to HIV/AIDS.[1]

In such a scenario, employers not only have the responsibility to act, but have an opportunity to play a crucial role in limiting the spread of the HIV/AIDS epidemic, particularly within their own workplace. Employers in vulnerable industries can contribute significantly to mitigate the impact of the epidemic by taking simple steps to ensure that their own workforce is free from HIV/AIDS.

National AIDS Control Programme (NACP IV) has proposed employer-led initiatives to reach vulnerable workforce in industrial sectors to limit the spread of HIV/AIDS epidemic in India.

Within the industry structures, the HIV/AIDS programme can be integrated in the existing systems and structures for the activities to be cost-effective and enhance the reach of activities to a wider

[1] Workplace HIV/AIDS programme, An action guide for managers, FHI 2002

audience. This in turn will reduce the vulnerability of industries to losses due to loss of skilled workforce.

- HIV/AIDS awareness programme integrated within existing trainings, systems and structures
- HIV/AIDS services integrated within existing health facilities

Our representative would like to meet with you and discuss the proposed activities at length. We request you to give us an opportunity to meet and discuss a potential Employer Led Model for your workforce.

Our team will be contacting you shortly. Meanwhile if you have any specific queries please do contact Ms. XYZ, Designation (mobile:....., email: xyz@abc.com)

Thanking you,

Sincerely

Mr. ZXY

(Designation)

Suggested Process for Pitch Presentation to Senior management at the Industries:

This is the most important opportunity to convince senior management about the importance of adopting an HIV/AIDS/TB intervention programme.

Objective of the pitch presentation:

- To present HIV/AIDS as workplace issues to decision makers in the company
- To convince decision makers to take up HIV/AIDS workplace interventions
- Collect information about the company to develop a customized proposal and budget work on HIV/AIDS workplace intervention

Target for pitch presentation:

Target for the pitch presentation is the decision-making authority in the company which could be --

- Chief Executive Officer
- Managing Director
- General Manager
- Vice-President HR
- HR Head

Presenting to middle-level management can flop because they might not be able to convince the decision-makers about the significance of the programme. This may either lead to the company not taking up the programme or result in a repetition of the pitch presentation.

Preparation for the meeting

- Prepare a presentation, not more than 10 minutes long, to explain HIV/AIDS global and local statistics, HIV/AIDS as a workplace issue, introduction about the model and the HIV/AIDS intervention strategy proposed
- Rehearse presentation with your colleagues and ask for suggestions
- Dress formally
- Be punctual
- Carry material about your organization
- Carry your visiting cards
- Carry a laptop to make a presentation
- Switch on laptop before you enter the cubicle of the concerned person to save time in booting it

Meeting process

- Be confident, greet the person, exchange cards and introductions
- Begin by saying, 'You must have received our letter about HIV/AIDS intervention in industries. We thought it would be useful if we meet you to explain it in detail. Thank you for sparing the time to hear us. I have a 10-minute presentation about the model. It would

be much easier to explain with the help of a presentation, so if it is okay with you, may I make a quick presentation?'

- Make the presentation
- Ask the person what he thinks of the intervention and how it would be possible to do ELM intervention at his/her company
- If the person is positive, explain the process thus, 'If you are agreeable to the programme, we can work with you to develop the intervention and proposal'.
- If the person needs some time to think or discuss with others, you may say, 'I will send you the proposal which describes our programme in detail. It would help you in discussing our programme with your colleagues. In case you want us to come and have a chat with them, we would be glad to do so.'
- Make sure you take the right e-mail id where he/she would like you to send the proposal
- Thank the person and take his/her leave

Follow up after the pitch presentation

- Develop a customized proposal with packages and budget
- Call and speak to the person 2-3 days later and find out the progress. If the person gives you a certain date when you should call him/her, put a reminder on your computer
- If the person wants you to make a pitch presentation with other colleagues, make another visit to the company and make a presentation
- It may happen that the company would like to take only a few components in the beginning, and based on their experience, might like to take it forward. For example, a company might want to have a senior management training first and then decide whether it wants to take up other components.
- If the person is agreeable, send him a draft -- 'Letter of Intent' (Annexure 5) -- and ask him/her to send it to you on a letterhead of the company signed either by the CEO, MD or a signing authority
- Begin ELM implementation, starting with senior management sensitization

Suggested Sample of Pitch Presentation for Senior Management and Gate Keepers

Reaching Industrial Workforce with HIV/AIDS Intervention

Sample Presentation for Sensitizing Gate Keepers

Presentation Outline

- Risk and vulnerabilities of Industry workers to HIV
- Why Industries should respond
- How Industries can respond
- The cost and benefit to Industries
- Roles of different players

Killer Diseases...

Cardiovascular disease (17 m)
Malaria (500 m people fall sererely ill)
Diarrhea related diseases (2.2 m)

then why

HIV/AIDS?

Because...

- HIV/AIDS affects the most productive age group of 15-49 years
- HIV infections can be prevented
- It is never possible to get the exact magnitude of the HIV:
- Impact beyond health – socio economic
- Key challenges in HIV prevention:
  - There are no immediate and exclusive symptoms of HIV
  - Discussion on sexual issues is a taboo
  - High levels of stigma and discrimination

And ..... HIV Epidemic is driven by a complex web of issues

Poverty & Social Exclusion

Gender Inequalities

Labor mobility, Transport & Trade

Culture, Social Norms & Practices

Unemployment rises from 3.6%-9.8%

Borrowings rises to 46% (PLHIV households) VS 27% (Non HIV households)

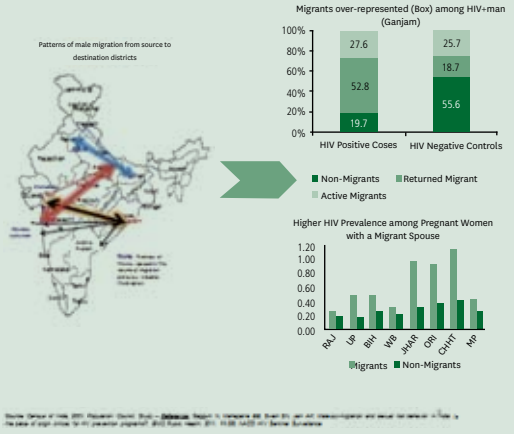
Per-capita expenditure 4 times higher than non HIV households

** NACO 2011; NACO-UNDP-NCAER 2006*

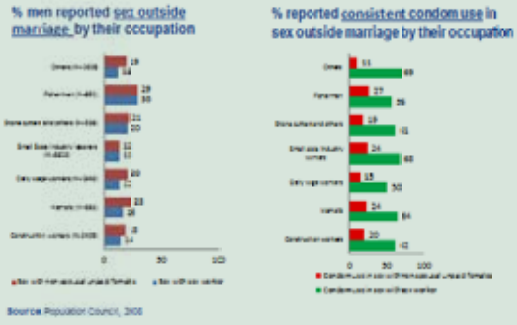
Scenario of HIV/AIDS: Global & India

Estimated Number of People Living with HIV/AIDS

Migration Emerging as a Vulnerability



Risky sexual behavior of male workers by the nature of their occupation



Emerging Evidence on risk of informal workforce

Findings	Year	Author
Among the more than 80 industrial sectors in costal AP Granite, Fisheries, Coffee, Automobile, Chilli Construction, Mango, Iron & Steel, Ports and Coconut sectors had larged clusters of informal workforce with significantly higher levels of risk behaviours related to HIV and AIDS	2009	PSI
Among industrial sectors in Karnataka with engage informal workforce in large scale revealed that mining, garment/textile, sugar, construction/infrastructure, and fishing industries were at higher HIV risk compared to other sectors	2009	Halli et al
The existence of a wide network of labour contractors and as structured infrastructure of the contract system provides opportunities for effective and sustained worksite HIV prevention programmes among contracted mate migrant workers in India	2008	Saggurti et al

HIV/AIDS: A Workplace Issue

How does HIV/AIDS affect Industries ?

- Loss of skills and experience
- Reduces supply and increases cost of labour
- Falling productivity
- Reduced profit and investment

HIV/AIDS: A world of work issue

How does HIV/AIDS affect Workers ?

- Loss of income and employee benefits
- Stigma and discrimination

PLHA's key message to the world of work

Examples of the impact of HIV/AIDS on enterprises

- A survey of 1006 firms in South Africa found that 43% of firms envisaged significant adverse impact within five years due to HIV/AIDS. 30% of them reported higher labour turnover, and 24% increased costs of recruitment and graining.
- A 14 firm study in Benin found that half of those employees identified as HIV positive held important positions.
- Standard Chartered Bank responded to HIV/AIDS when they found that in one country 10% of the staff was absent due to HIV related matters.
- A six firm study by Rosen and co-authors in Botswana and South Africa found that AIDS would impose costs between .4% to 5.9% of the annual wage bill in next ten years.

Source: ILO, 2005

Evidence of rising costs due to HIV/AIDS in India companies

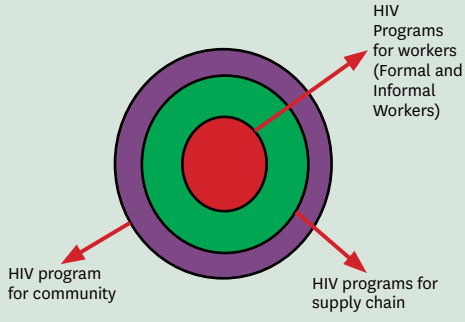
- A coal company in A.P. spent Rs. 65 lakhs (US$144,000) in previous five years in lump sum payment to 29 employees, declared unfit to work due to HIV/AIDS (an ILO study 2005)
- The Employees State Insurance Corporation scheme spent Rs. 12.22 lakhs (US $28,400) in providing ARV tratment to 236 ESIC beneficiaries in 2003-4.
- The BEST (Brihna mumbai Electric Supply and Transport Undertaking Ltd. Mumbai is spending nearly Rs. 2 lakhs (US$ 4600) per month in providing ARV treatment to 120 employees, BEST has a comprehensive policy and programme. With this support, employees are able to work.

Source: ILO, 2005

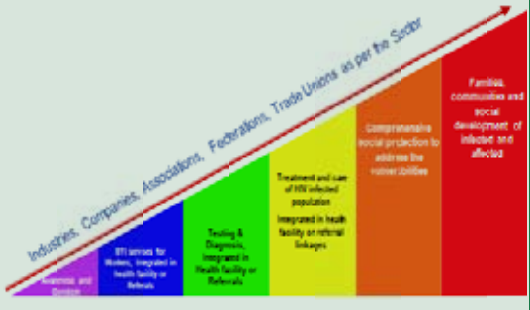
Why should business get involved ?

- **For economic reasons:** In some instance, HIV/AIDS/TB can result in increased costs and reduced productivity
- For a **Positive Business Image which can** have both economic and social returns
- To be good corporate citizens, beyond normal business operations or employee welfare and satisfy **Corporate Social Responsibility**
- HIV/AIDS can be prevented, and prevention is the only answer in the absence of a cure
- Businesses can do so best by offering prevention information and services to the employees, their families and communities at large

How can industreis respond to HIV/AIDS?



Menu of options



Expectations from Employers

Industry with health facilities

- Treatment for STI
- ICTC/PPTCT Services
- ART and care and treatment services
- IEC services throgh peer outreach

Industry without health facilities

- Health camps for STI
- Linkages with mobile/facility based govt ICTC
- Linkages with ART and care & treatment facilities
- IEC services through peer outreach

Programme Components

Prioritizing Industreis basis risk and vulnerability of Informal workers

Senior Management Sensitivization from Identified Industries in collaboration of sectoral associations

Structures/Systems to be leveraged Existing health facilities, cost of providing services, HR/Welfare/health safety program

Service Delivery (Own Health Facility)

- **Integrating** HIV/AIDS/STI & TB services within the health facilities
- **MOU with SACS** for PPP and integrating services
- **CSM through SMOs**

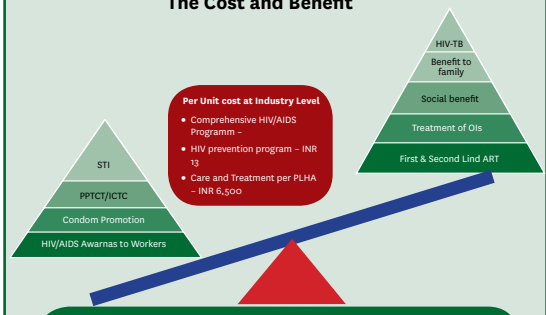
Service Delivery

- **Regular on site health camps -** Cost paid by company
- Referral linkages to ESIC, empaneled doctors
- **Referrals/Mobile** ICTC from SACS-Cost by company
- **CSM through SMOs**

Awareness and Demand Creation

- **Integrating** within existing activities of HR/Welfare/H&S
- Peer educators among contract workers
- **Using Employee**

The Cost and Benefit



The return on investment in the prevention of HIV far exceeds that of standard capital investments. Studies have indicated that these returns, in terms of cost savings through preventing HIV, are as much as 3.5 to 7.5 times the cost of intervention

Role of key stake holders

DAC

- Overall policy disrections and guidance

SACS/TSU

- Responsible for facilitation state level
- Technical support to industries

DAPCU

- Facilitation at district level or in a cluster of districts

Employer Structures

- Overall lead in implementation
- Integrated HIV/AIDS in existing systems and structures
- Ownership of ELM
- Initiate and sustain ELM

Employer Associations

- Advocacy with Employers
- Sensitization of Employers on the issue of HIV/AIDS

Trade Unions

- Need based Implementation support to Employers
- Facilitate interventions along with employers

Other Stakeholders

- Facilitate an enabling environment

You must be the change you wish to see in the world...

-- Mahatma Gandi

Annexure 9: Detailed Guidelines for STI Management Services within Industry

Minimum Infrastructure Required

- **Waiting area:** The facility should have waiting area where patients can wait while another patient is busy with the doctor for consultation. The waiting area should have a condom box and takeaway IEC material on HIV/AIDS and STI.
- **Consultation room:** The consultation room should measure at least 10' X 10'(feet). The consultation room should have sufficiently thick walls and a door to ensure auditory and visual privacy. The consultation room should be used for case-taking, counselling and physical examination.

Equipment and Supplies for STI/RTI Service Provision

- **General medical instruments:** sphygmomanometer, stethoscope, thermometer, examination table with recess/lithotomy cut and adult weighing scales
- Disposable Cusco's vaginal specula of various sizes (where services for women are provided) should be available.
- Steriliser or access to sterilisation (e.g. autoclave), instrument tray and forceps
- Segregated bins to collect infectious waste before disposal
- Medical supplies such as disposable gloves, needles and syringes, needle cutter

Minimum Furniture and General Items

- Lockable cupboards/shelves for patient records and drug supplies
- Storage area for condoms, other supplies and stationery
- Sink with running water for washing hands, cleaning instruments, etc.
- Tables, chairs and stools for staff and patients
- Fans and adequate lighting in waiting and consultation areas
- Waste disposal system

Other Essential Supplies for STI/RTI Service Provision

- Male condoms
- Job aids for clinic staff, e.g., penis models for demonstrating correct condom use, syndromic management flow charts to aid patient management, posters on infection control and anaphylaxis management
- IEC materials, e.g., posters, flip charts and handouts to provide messages on how to protect against infections, symptoms of STIs/RTIs, and steps to be taken to effectively treat infections

Essential STI/RTI Kits & Drugs for Clinics

Clinics should maintain adequate stocks of STI/RTI pre-packed kits and essential STI/RTI

drugs (as per standard treatments) at all times. A minimum of a three-month stock of all kits, drugs and supplies should be maintained at all times.

Kit No.	Syndrome	Colour	Contents
Kit 1	UD, ARD, Cervicitis	Grey	Tab. Azithromycin 1 g (1) and Tab. Cefixime 400 mg (1)
Kit 2	Vaginitis	Green	Tab. Secnidazole 2 g (1) and Tab. Fluconazole 150 mg (1)
Kit 3	GUD	White	Inj. Benzathine penicillin 2.4 MU (1) and Tab. Azithromycin 1 g (1) and Disposable syringe 10 ml with 21 gauge needle (1) and sterile water 10 ml (1)
Kit 4	GUD	Blue	Tab. Doxycycline 100 mg (30) and Tab. Azithromycin 1 g (1)
Kit 5	GUD	Red	Tab. Acyclovir 400 mg (21)
Kit 6	LAP	Yellow	Tab. Cefixime 400 mg (1) and tab. Metronidazole 400 mg (28) and Cap. Doxycycline 100 mg (28)
Kit 7	IB	Black	Tab. Doxycycline 100mg (42) and Tab. Azithromycin 1 g (1)

Minimum Clinical Management at STI/RTI Facility

- Sexual health history-taking
- Adequate and appropriate physical examination
- Appropriate and immediate treatment as per national guidelines
- Counselling of every patient, including the "four C's" (Condom Demonstration and Promotion, ensuring Compliance with Treatment, Counselling and Contact treatment/ Partner Management)
- Follow-up care including examination of patient to know the status of STI /RTI after treatment
- Partner management as described below
- Referral network for services not available at clinic (e.g., referral for Syphilis testing if it is not available on-site, ICTC, Tuberculosis, ART services)

Partner Treatment

- Partner management includes examination and treatment of regular/permanent sex partner (e.g., spouse) of the index patient. For this purpose, the partner may be asked to visit the same STI/RTI clinic or referred to any other STI/RTI clinic that the partner feels comfortable visiting, or treatment may be provided to the index patient to deliver to the partner. Any of the above decisions are to be taken only after discussion/counselling with the index patient according to his/her convenience

Follow-up visit

At the follow-up visit, a detailed history (including compliance with treatment and possible re-infection) and examination should be carried out to find out if the patient is responding to treatment. If so, the patient should be advised to continue the remaining treatment and counselled on preventing future infections. If the patient is not responding to treatment, explore whether treatment was completed and partner has been treated. If not, ensure treatment compliance.

Annexure 10: Detailed Guidelines for ICTC Services at Industry Level

Minimum Physical Infrastructure Required for ICTC

In a facility, the ICTC should be located in a place that is easily accessible and visible. The ICTC should consist of a counselling room and a laboratory room.

Counselling room

The counselling room should be an enclosed space, ideally 15' X 15' in area so that one-on-one and one-on-group counselling sessions may be undertaken in an atmosphere of privacy. The minimum requirement for furniture and equipment for a counselling room:

- Desk for the counsellor
- 10–15 chairs for one-on-one and group counselling sessions as well as for the waiting area
- Lockable filing cabinet for keeping records
- Computer with printer and UPS
- Waste basket.

Aids to Communication which must be available in an ICTC:

- Posters and information materials on the walls
- Communication aids such as flip charts
- Condom-use demonstration models
- Leaflets/pamphlets as take-home material for clients

Laboratory room

The lab should have an area of at least 10' x 10'. Equipment required for testing in an ICTC are:

- Refrigerator
- Centrifuge
- Needle destroyer
- Micropipette
- Colour-coded waste disposal bins

Consumables required for collection and testing of blood in ICTC:

- Sterile needles and syringes
- Disposable gloves
- Vials and tubes for collection and storage of blood
- Cotton swabs
- Cleaning material such as spirit/antiseptic lotion
- Bleach/hypochlorite solution
- Microtips for use in micropipettes

In order to provide PPTCT services to pregnant women who are HIV-positive, all ICTCs are required to have an infantometer as well as an adequate stock of Nevirapine tablets and syrup.

Components of HIV/AIDS counselling and testing

HIV/AIDS counselling/education is a confidential dialogue between a client and counsellor aimed at providing information on HIV/AIDS and bringing about behaviour change in the client. It is also aimed

at enabling the client to take a decision regarding HIV-testing and to understand the implications of the test results.

Steps in HIV/AIDS-counselling:

- HIV pre-test counselling/information: This involves provision of basic information on HIV/AIDS and risk assessment to direct walk-in clients
- HIV post-test counselling: The client is helped to understand and cope with the HIV test result

In case of a negative test result, the counsellor reiterates basic information on HIV and assists the client to adopt behaviour that reduces the risk of getting infected with HIV in the future. In case, the client is in the window period, a repeat test is recommended. Those clients with suspected tuberculosis are referred to the nearest microscopy centre.

In case of a positive test result, the counsellor assists the client to understand the implications of the positive test result and helps in coping with the test result. The counsellor also ensures access to treatment and care, and supports disclosure of the HIV status to the spouse.

Follow-up counselling: In follow-up counselling there is a re-emphasis on adoption of safe behaviour to prevent transmission of HIV infection to others. Follow-up counselling also includes establishing linkages and referrals to services for care and support including ART, nutrition, home-based care and legal support.

Settings for Counselling

Counselling and testing services may be offered to clients who are referred by medical providers or to clients who come to an ICTC of their own volition. The two settings in which counselling and testing can be offered to clients are as follows:

- Provider-initiated counselling and testing
- Client-initiated counselling and testing or self-referred, direct walk-in

HIV Testing and Quality Assurance Protocols (as Per National ICTC Guidelines)

Training of Staff

Induction training

All counsellors and LTs who are newly appointed to an ICTC need to undergo training as per the DAC-recommended training curriculum at DAC-designated centres of excellence as per national guidelines. The SACS – BSD will be conducting the training of staff at PPP hospitals.

Ongoing/Refresher training

ICTC counsellors and LTs should undergo refresher training provided by DAC at least once a year to upgrade their knowledge and skills.

Full-site sensitization

All staff in a facility which has an ICTC, including superintendents of hospitals, civil surgeons, nurses, administrative staff, pharmacists, X-ray technicians and ward boys, need to be sensitized about specific issues related to HIV/AIDS such as the importance of HIV counselling, confidentiality, PEP, universal precautions and maintaining a respectful and non-discriminatory attitude towards PLHA. The person in-charge of the ICTC will be responsible for undertaking a full-site sensitization at least once a year.

Annexure 11: Detailed Guidelines for ART Services at Industries

Functions of ART centre

PLHIV should be given holistic care at ART centres. This is possible only if the team at the centre is committed and has a comprehensive understanding of the programme. Functions of ART centre can be categorised as medical, psychological and social and are indicated below:

Medical functions

- To monitor, manage and follow up on pre ART patients
- To diagnose and treat opportunistic infections including primary and secondary prophylaxis as per guidelines
- To screen PLHIV for clinical eligibility and to initiate ART as per DAC ART guidelines
- To provide ART to eligible PLHIV and counsel them on 100% adherence to therapy for long term effectiveness of ART
- To monitor patients on ART and manage side-effects, IRIS, etc. (if any)
- To provide in-patient care as and when necessary

Psychological functions

- To provide psychological support to PLHIV accessing the ART centre
- To provide counselling to "Pre-ART" and "On-ART" patients on regular follow-up visits and CD4 testing
- To provide counselling for adherence to ARV drugs and issues related to toxicity
- To educate PLHIV on proper nutrition and measures to prevent further transmission of infection
- To advise for risk reduction behaviour including usage of condoms
- Encouraging, educating and counselling to help patients disclose HIV results to spouse/ children/family/caregiver

Social functions

- To encourage and help PLHIV access various welfare schemes provided by different ministries/departments of government and accredited, social entitlement schemes
- To facilitate linkages between other service providers and patients, like educational help for the children and income generation programmes, etc.
- Helping them in accessing legal help when the need arises
- To facilitate linkages between other governmental, non-governmental organisations and service providers such as CCC, DIC, STI, DOTS, NGOs, etc.

Steps for Setting Up ART Centres

Step 1. Identification of proposed site for new ART Centre (during AAP planning) SACS/ Discussion with DAC

Step 2. Provisional sanction (during April every year as per AAP) DAC

Step 3. Feasibility visit of site by an expert team constituted by SACS in consultation with Regional Co-ordination (RC) and approved by DAC

Step 4. Submission of feasibility report in prescribed format to DAC Expert Team

Step 5. Training of ART team (multidisciplinary faculty team) DAC/SACS

Step 6. Recruitment of contractual staff at ART centre (By coordination committee at the industry level) institution/SACS

Step 7. Training of all staff at the industry-linked health facility

Step 8. Linkages with CD4 testing

Step 9. Linkage with DAC CMIS & supply of M&E tools DAC & SACS

Step 10. Supply of ARV drugs to new centres SACS/Supply Chain

Step 11. Operationalisation of ART Centre Institution/SACS

Feasibility Assessment for ART Centres

A feasibility assessment team comprising officers from DAC/SACS and an ART expert visits the identified site, after a provisional administrative sanction is issued for setting up a new ART centre.

The team assesses feasibility of starting the ART centre on the basis of a checklist on parameters given in National ART Guidelines. The feasibility report is then submitted to DAC for the issuance of final sanction on examination of the report. The institution should appoint HOD Medicine as nodal officer for ART (or a senior faculty member from department of medicine nominated by HOD).

They will also meet the dean/MS and the multidisciplinary team besides visiting the proposed site for ART centre. Written consent of the institution for rolling out of ART services, in accordance with the operational and technical guidelines, is required.

Space, commitment, availability of free investigations and hospitalisation, without discrimination, are key criteria for approval by the team.

Final Operationalization of ART Centre

The ART centre -- after initial preparatory work such as refurbishment of the centre, purchase of furniture, recruitment and training of contractual staff, supply/linkage of CD4 machine, etc. have been carried out -- shall be inspected again by RC/SACS official. Only after a satisfactory report from the team, shall the centre be supplied with ARV drugs and declared as functional after submission of the first monthly report.

Staffing Pattern for ART Centres

All ART centres should have manpower in proportion to the number of patients on ART at each centre.
Currently approved staffing pattern for ART centre:

- Medical officer
- Lab technician*
- Counsellor
- Pharmacist
- Data manager

- Staff nurse
- Care coordinator

Capacity Building of ART Centre Staff

To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, induction training is provided to various personnel using standard curriculum, training module and tools at identified institutions. Various training programmes organized for ART staff:

- Orientation of 'ART team' members from institution (4 days)
- Training of Medical Officers (SMO/MO) of ART centres (12 days)
- Training of counsellors (12 days)
- Training of data managers of ART Centres (3 days)
- Training of laboratory technicians for CD4 testing (2 days)
- Training of pharmacists (3 days)
- Training of nurses (6 days)

Annexure 12: STI/RTI Monthly Reporting Form for Industry-Linked STI/RTI Clinic Through ELM

SACS will provide user id and password to the industries for monthly reporting in SIMS. For all reporting purposes and reporting purposes on STI, ICTC and ART services, reporting format of SACS would be used. The following section includes samples of reporting formats currently in use.

Monthly STI/RTI

Unique ID. No. of STI/RTI Clinic /Gynae OPD /TI NGO	

MONTHLY REPORT FORMAT FOR STI/RTI CLINICS

Name of STI/RTI Clinic/ Hospital to which the Gynecology OPD is Attached/ TI NGO					
Sub Type		Category		Location	
Address :					
District :		Block :		City :	
Reporting Period :	Month(MM) :		Year(YYYY) :		
Name of Officer In - charge :					
Phone no. of Officer In - charge :					

Section 1 : No. of Patients Availed STI/RTI services in this month

Type of Patients	Age Group & Sex												Total		
	<20			20-24			25-44			>44					
	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG
Clinic visit with STI/RTI complaint and were diagnosed with an STI/RTI															
Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI. • Clinic visit for Syphilis Screening (Excluding ANC) • For TI-NGOs-RMC, PT, Syphilis Screening (whichever applicable)															
Follow up visit for the index STI/RTI complaint															
Total No of visits															

Section 2 : STI/RTI syndromic diagnosis

(Should be filled by all STI/RTI service providers for clinic visit for STI/RTI complaint only)

Diagnosis	Age Group & Sex			
	Male	Female	TS/TG	Total
1. Vaginal/ Cervical Discharge(VCD)				
2. Genital Ulcer (GUD) - non herpetic				
3. Genital ulcer(GUD) – herpetic				
4. Lower abdominal pain (LAP)				
5. Urethral discharge (UD)				
6. Ano-rectal discharge (ARD)				
7. Inguinal Bubo (IB)				
8. Painful scrotal swelling (SS)				
9. Genital warts				
10. Other STIs				
11. Serologically + ve for syphilis				
Total No of episodes				
No of people living with HIV/AIDS (PLHAs) who attended with STI/RTI complain during the month				

Section 3. Details of other services provided to patients attending STI/RTI clinics in this month

To be filled in by all STI/RTI Service Providers

Service	Male	Female	TS/TG	Total
1. Number of patients counseled				
2. Number of condoms provided				
3. Number of RPR/VDRL tests conducted				
4. Number of patients found reactive				
5. Number of partner notification undertaken				
6. Number of partners managed				
7. Number of patients referred to ICTC				
8. Number of patients found HIV-infected (of above)				
9. Number of patients referred to other services				

Annexure 13: STI/RTI Patient Card Formats:

Patient Wise card-STI services

Doctors Name : _____
Qualification : _____
Phone No : _____
Email No : _____

Name of the Clinic: _____
Clinic Timing: _____
Address : _____

NAME OF PATIENT : _____ Index No. _____ Date _____

AGE SEX MALE ☐ FEMALE ☐ TRANSGENDER ☐

Typology: FSW ☐ MSM ☐ IDU ☐ Migrants ☐ Truckers ☐

PATIENT FLOW : DIRECT WALK IN ☐ REFERRED ☐

Type of Patient:
New ☐
Old ☐

Purpose of visit:
Symptoms & Signs of STI ☐
Follow up ☐
PT ☐
RMC ☐

Presenting complaint _____ since when _____

STI/RTI SYNDRROMIC DIAGNOSIS	KIT PRESCRIBED	Name of the drugs	Counselling	
				Yes
* Urethral Discharge (UD) * Ano- Rectal Discharge (ARD) * Cervical Discharge (Cervicitis) * Presumptive treatment (PT) * Painful Scrotal Swelling (PSS)	KIT – 1 GREY	Azithromycin (1 g) OD STAT Cefixime (400 mg) OD STAT		No
Vaginal Discharge (Vaginitis)	KIT – 2 GREEN	Secnidazole (2 g) OD STAT and Fluconazole (150 mg) OD STAT	REFERRAL	
Genital Ulcer Diseases (GUD) - Non Herpetic	KIT – 3 WHITE	Benzathine penicillin (2.4MU) IM STAT and Azithromycin (1 g) OD STAT		ICTC / PPTCT
GUD- Non Herpetic (Allergic to Penicillin)	KIT – 4 BLUE	Doxycycline (100 Mg) × BD × 14 Days Azithromycin (1 g) × OD STAT		LAB TEST RPR/VDRL
GUD Herpetic	KIT – 5 RED	Acyclovir (400 mg) × TDS × 7 Days		ART CENTRE
Lower Abdominal Pain (PID)	KIT – 6 YELLOW	Cefixime (400 mg) × OD STAT and Metronidazole (400 Mg) × BD × 14 Days and Doxycycline (100 mg) × 14 Days		OTHERS:
Inguinal Bubo	KIT – 7 BLACK	Doxycycline (100 mg) × BD × 21 Days and Azithromycin (1 g) × OD STAT		
Other STI (Please Specify diagnosis and treatment)				

Examination Findings:

A) Partner notification undertaken : Yes/ No

B) Next Visit Date:

C) Condoms Provided: Yes/ No (if yes, Number:)

Others:

Date:

Signature of Doctor

Guidelines for Filling STI/RTI Patient Wise Card and Monthly Reporting Formats

Who should fill the cards ?

The STI/RTI patient wise card should be filled by STI/RTI service providers at industry level for each new STI/RTI episode treated. The cards should be stored securely to maintain confidentiality.

The monthly reporting format should be filled by using the consolidated data from these cards. The filled cards should be available at clinic during monitoring and supervisory visits by the nodal officer and coordination committee.

STI/RTI service providers at industry level

- Medical doctor at STI clinics integrated within health facility linked with the industry
- Medical doctor conducting health camp at the industry site
- Preferred provider doctor appointed by the industry for providing health services

Specific instructions

STI/RTI risk assessment

- Check box after taking detailed 'Medical History' from patient
- Check box after taking detailed 'Sexual History' from patient
- Check box after conducting detailed 'Physical Examination' of patient
- Check box after conducting detailed 'Internal Examination' of patient
- Write key points of significance from history in the box provided

STI/RTI syndrome diagnosis

- Check appropriate box as per diagnosis made
- While making syndrome diagnosis, standardized definitions given ONLY to be followed.
- Should be filled in for first clinic visit for index STI/RTI complaint only
- Should be filled in even if diagnosis is made on clinical or etiological basis
- If patients have more than one syndrome or condition, check all appropriate boxes

Examination findings

Summarize the salient findings of physical including internal examination, in the box provided.

Details of STI/RTI treatment given

This section has 'four' components

- Pre-specified colour-coded kits starting from No. 1-7
- Check the box against kit administered to patient
- If more than one kit is given to the same patient due to multiple syndromes, then check relevant boxes
- General medicines administered to patient
- Check relevant box, if any of these medicines were administered
- If drugs for anaphylaxis are checked, detail the entire management of anaphylaxis including the outcome on a separate sheet and append to the card
- All drug allergies, idiosyncratic reactions to be marked with red ink on the card
- If kits are not in supply, or in addition to kits, loose drugs are prescribed/administered, then check relevant boxes. Write any other drug administered or prescribed to patient which does not fall in any of the above mentioned categories

Annexure 14: Mentoring and Support Visit Checklist for STI/RTI Services

Name of industry				
Location				
Date of monitoring and supervisory visit				
Name and signature of members visited				
Key Areas		**Yes**	**No**	**Remarks**
1. Separate consultation area with auditory and visual privacy		Y	N	
2. Equipment (physical verification)				
• Examination bed with bed sheets and drapes				
• Lighting for examination				
• Instruments-speculum, proctoscope, etc.				
3. Consumables available (physical verification)				
• All First Line STI/RTI drugs and kits				
• Condoms (male/female/free/socially marketed; whatever applicable)				
• Disposable syringes with needles				
4. Documentation is complete and up-to-date (physical verification)				
• STI/RTI patient wise card				
• Drugs and condoms inventory				
• Monthly summary reports				
• Discrepancy of data submitted to SACS				
5. Prescription audit:				
• Select randomly 10 STI/RTI patient wise cards of last quarter. Check diagnosis, perform investigations and administer kit/drugs as per guidelines				
• Note number of cards reviewed				
• Note number of cards that are incomplete/incorrect/inconsistent as per guidelines				
6. Infection control measures (observation):				
• Hand washing before and after examining patients				
• Gloves used for ano-genital examination				
• Re-usable instruments are decontaminated, washed and sterilized				
• Waste disposal system in place				
7. Does staff require re-orientation/training				

8. Referrals from and to STI/RTI clinic: Write quantum, and check maturity of referrals in the last quarter				
• Number of referrals received from peer educators				
• Number of patient referred to other facilities				
9. IEC and technical materials				
10. Job aids (disinfection chart, flip chart, etc.)				
• IEC material for patient education (posters and pamphlets)				
Quality Indicators				
% of patients with medical history recorded				
% of patients with sexual history recorded				
% of patients with physical examination conducted				
% of patients given correct drug for each syndrome treated				
% of patients with whom discussion on partner treatment was done				
% of patients with whom risk reduction was discussed				
% of patients with whom importance of condom use was discussed				

Annexure 15: ICTC Services Monthly Reporting Format for PPP-ICTC Integrated Within Health Facility Linked With Industry

Name of industry				
Address				
City	District		State	
Reporting period	Month		Year	
Name of ICTC incharge				
Name of Nodal person				

Summary table :				
Indicator	**ICTC Clients (Excluding Pregnant Women)**		**ICTC Clients Pregnant Women**	**Total ICTC Clients**
	Male	**Female**		
Total clients registered for ICTC in the month				
No. of clients receiving pre-test counselling				
No. of clients tested for HIV				
No. of clients receiving post-test counselling				
No. of clients receiving post-test result				
Total no. of clients tested sero positive (after 3 specified tests)				
No. of mother-baby pairs received Nevirapine out of those found HIV positive				
No. of ICTC clients referred to microscopy centres/ DOTS centres				
No. of TB clients referred in ICTC from microscopy centres				
Total no. of HIV – TB co-infections reported in the month				

Laboratory information for ICTC	
Description	**Units**
1. Total no. of blood specimens from ICTC tested this month	
2. Total no. of blood specimens found indeterminate (after 3 HIV tests)	
3. No. of HIV positive specimens sent for confirmation	
3 a) No. of specimens confirmed positive	
4. No. of negative specimens send for confirmation	
4 a) No. of specimens confirmed negative	

Linkages and referrals						
Departments/ Agencies	**In Referral**		**Out Referral (Positive)**		**Out referral (Negative)**	
Peer educators						
RNTCP						
Government health facility						
ART centre						
STI clinics						
Care centre (CCC) and DIC						
Any other						

For Industries-Linked PPTCT Services

Pregnancy and Delivery		
Indicators	**During ANC**	**During Delivery**
No. of new registrations		
No. of cases receiving pre-test counselling/information out of all ANC registered		
No. of cases tested for HIV		
No. of cases received HIV test results		
No. of cases received post-test counselling		
No. of cases diagnosed HIV-positive		
No. of HIV-positive cases received HIV test result		
No. of spouses/partners of HIV-positive women found HIV-positive		
No. of spouses/partners of HIV-negative women found HIV-positive		
Total no. of deliveries this month		
Total no. of HIV-positive deliveries this month		
Total no. of live births to HIV-positive mothers		
Total no. of mother–baby pairs who received Nevirapine		
No. of HIV-positive pregnant women receiving Nevirapine during the month		
No. of HIV-positive women opting for exclusive breast-feeding		
No. of HIV-positive women accepting MTP after counselling		
No. of babies of HIV-positive receiving Nevirapine during the month		

Follow-Up	
Description	**Current Month**
1. No. of HIV-positive women turning up for follow-up in sixth week	
2. No. of babies undergone HIV diagnostic testing (PCR)	
3. No. of babies found positive	
4. No. of mothers counselled for breast-feeding	
5. No. of positive mothers counselled for family planning	
6. No. of HIV-positive women turning up for follow-up in sixth month	
7. No. of babies of HIV-positive women undergone HIV diagnostic testing (PCR) in six-month follow-up	
8. No. of babies found positive in six-month follow-up	
9. No. of positive women turning up for follow-up a in 12th month	
10. No. of babies of positive women turning up for follow-up in 12thmonth	
11. No. of positive women turning up for follow-up in 18thmonth	
12. No. of babies of positive women turning up for follow-up in 18thmonth	
13. No. of babies found HIV-positive in 18thmonth	
14. No. of clients referred for CD4 testing	

Guidelines for Monthly Reporting Formats

Who Will Fill Monthly Reports

The nursing staff trained as counsellor will fill in the monthly report and send across to the medical doctor. The medical doctor will verify the report and send across to the nodal officer for final entry of data in the overall monthly report send across by the industry to SACS.

The functioning of ICTC integrated within health facilities linked with industries will be as per the PPP-ICTC guidelines

Annexure 16: Checklist for Mentoring and Support Visits ICTC Services

Checklist for Mentoring and Support Visits

Date:

Name of industry:

ICTC site incharge:

Objectives:

- Assess adherence to protocols
- Assess availability of health education materials and condoms
- Assess availability and use of record-keeping formats
- Assess availability of test kits and medical consumables
- Assess adherence to staff roles and responsibilities
- Assess general aspects of site operations

Staffing as per guidelines:

Availability of Test Kits, Medical Consumables & Procedures (Adapt as Required for Site)

Type of Material	Available	Not available	Comments
1strapid test			
2ndrapid test			
3rdrapid test			
Medical consumables available			

Role of Counsellor	Yes	No	Comments
Confidentiality discussed with client			
Obtains informed consent			
Pre-test counselling conducted			
Condom demonstrations performed			
Uses counselling tools with client as appropriate			
Blood drawn per guidelines if applicable			
Written test results and copy of consent form attached only given in person			

Role of Laboratory Technician	Yes	No	Comments
Technician adheres to all safety procedures			
Ensures laboratory is well-equipped			
Ensures blood samples have client's number sticker secured and sample packages as per guidelines			
Copy of test results put in test file and kept confidentially in lab			
Test results recorded in laboratory registers			
External quality control procedures adhered as per guidelines			
Internal quality control procedures adhered as per guidelines			

(ICTC SITE MANAGER) **(Nodal Officer-Coordination Committee)**

Annexure 17: Quarterly ART Reporting Format for Private Sector

Name of industry				
Reporting month and year				
Name of ART incharge				
Address of ART linked with industry				
E-Mail ID				
Contact number				
Signature				
	Male	Female	Children	Total
No. of PLHIV registered for HIV care				
No. of PLHIV ever started on ART				
No. of PLHIV currently on ART				
No. of PLHIV initiated on First Line ART (NNRTI)-based Regimen				
No of PLHIV switched to Second Line ART (PI-based) due to treatment failure				
No. of PLHIV started on an initial second line ART (PI-based)				
No. of patients referred to government ART centre				
Guidance on Rational ART Regimen				
First Line ART Regimen	2 NRTI (or 1 NtRTI + 1 NRTI) + 1 NNRTI			
Alternate First Line ART Regimen	2 NRTI (or 1 NtRTI + 1 NRTI) + 1 PI (Due to NNRTI Toxicity)			
Second Line ART	2 NRTI (or 1 NtRTI + 1 NRTI) + 1 PI (Due to Treatment Failure)			

Guidelines for Quarterly Reporting Formats

Who Fills Monthly Report: The medical doctor at the ART centre will be in charge of ART and fill the quarterly reporting format. He will send it across to the nodal officer in charge of ELM at the industry level.

The nodal officer, incharge of ELM, will be responsible for including ART services data in the quarterly report sent to the SACS on the overall ELM.

Annexure 18: Checklist for Quarterly Mentoring and Support Visits for ART Centre at Industry Level

This checklist is to be used by the designated supervisory team in conjunction with the ARV treatment unit staff during their visit to an ART centre. The aim is to see their quality of services offered, conformity to national guidelines, ability to identify problems and take corrective actions (the form should be signed off by the support visit team).

Name of industry: Date of visit:

Name of ART unit incharge: Name and signature of support visit team:

Key Areas	Yes	No	Remarks
Functioning of ART Centre			
Is proper space and infrastructure available at ART centre?			
Are there proper signages within hospital for ART centre?			
Is ART unit staffed as per DAC guidelines? (SMO, MO, lab technician, counsellor, pharmacist, DEO, nurse, care coordinator)			
Are ART services well organized? It will be indicated by flow of movement of patient to access services as required (clinical, lab, drugs, counselling)			
Is the SOP for functioning of ART centre being followed as per operational guidelines (specifies roles and responsibilities, patient flow, etc.)?			
Has sensitization of all the hospital staff been carried out?			
Recording and Reporting			
Are DAC-specified patient and programme monitoring records being maintained? i. Pre-ART register (HIV care) ii. ART enrolment register iii. Drug stock register iv. Drug dispensing register v. Patient treatment record (white card for pre-ART & on ART patient) vi. Green book (for pre-ART & on ART)			
Is confidentiality of records maintained?			
Are records properly stored?			
Are patient treatment records up-to-date?			
Pre-ART and ART Services			
Is CD4 testing been done every six months for all registered patients (pre and on ART)?			
Is pre-ART CD4 due list being maintained and followed?			
Are eligibility criteria for initiating ARVs being followed?			
Are national guidelines for ART being followed?			

Are all patients eligible for ART initiated on ART?			
Is there a mechanism in place to track back patients with borderline CD4 results?			
Is adherence issue being given due importance (adherence counseling, pill count)?			
Drug Stocks			
Are adequate drugs available for the next three months (stock position)?			
Are drugs stored as per specifications?			
Is the "First Expiry First Out" principle followed?			
Are there adequate measures in place to prevent pilferage?			
Has any physical verification of available stock been done in last three months (and by whom)?			
Does regimen-wise consumption of drugs match with no. of patients on ART?			
Laboratory Services Availability			
Microbiology lab with adequate space and technical expertise			
Biochemistry and hematology labs with adequate space and technical expertise			
Are baseline tests being done for all patients?			
Is CD4 testing done daily?			
Referral Linkages			
Are there referrals from ICTC to ART Centre (write the no. for the last three months) ? Compare with total positives detected at ICTC for the same period			
Are HIV/ TB linkages maintained (check linelist register and monthly report)?			
Is a proper MIS/ LFU tracking mechanism in place?			
How many LFU have been tracked back by CCC/DLN, during the last three months out of the list and shared?			
Other Information			
Are PEP drugs available in casualty, ICU & labour room?			
Are consumables for universal work precautions available?			
Are ART staff vaccinated for Hepatitis B?			
Are measures for airborne infection control in place?			
Are meetings with nodal officer, faculty and staff regularly held?			

Summary Recommendations of Supervisory Visit

Problem Identified	Recommendations	Responsible Person
Organization of services		
Uptake of services		
Treatment and follow-up		
Technical knowledge of staff		
Drugs and logistics		
Record maintenance		
Others		

Annexure 19: Employer-Led HIV and AIDS Intervention Model Monthly Reporting Format

Monthly REPORTING FORMAT for Employer Led Model								
Name of industry		**Type of industry**						
State:		**District:**		**Block/Mandal/Taluk**				
ELM started in:				**Reporting month:**				
Total number of migrant informal workers:		**Category**		☐ **With health facility** ☐ **Without facility**				
Name of nodal person:		**Phone No.:**						
Email-ID :		**Having own health facility (Y/N):**						
Indicators for Reporting						**Male**	**Female**	**Total**
Section 1 : Coverage of Informal Workforce								
1. Total no. of informal workers associated with the industry								o
2. Of the total informal workers registered, no. of new informal workers registered this month								o
3. No. of outreach sessions conducted during the month by master trainers (staff trained in conducting sessions)								o
4. No. of informal workers covered through outreach sessions conducted during the month								o
5. No. of street theatres/nukkad natak conducted during the month								
6.No.of informal workers reached through Mid Media								
Section 2 : Condom Availability								
Type of Commodity	**Opening Stock at Beginning of Month**	**Received/Purchased During the Month**	**Number Distributed/ Sold**	**Closing Stock at End of Month**	**Stock Sufficient for No. of Months**			
1. Free condoms				**o**	**o**			
2. Condom Social Marketing				**o**	**o**			
1. Total no. of functional outlets established for social marketing of condoms, in and around the industry, till this month								
Section 4 : ICTC/PPTCT Services								
Male							**Female**	**Total**
1. Total no. of individuals provided pre-test counselling through integrated ICTC during the month								o

2.Total no. of post-test counselling			
3. Total no. of clients tested			
4.Total no. of clients tested HIV positive			
5. Total no. of clients referred for ART			
6. No. of ANC women provided pre-test counselling			
7. No. of ANC women provided post-test counselling			
8. No. of HIV positive pregnant women			
9. No. of mother-baby pairs receiving ARV prophylaxis			
10. No. of informal workers referred for ICTC/PPTCT services in case of no integrated ICTC services			
Section 5 : ART Services			
1. No. of individuals referred for ART services to government ART centres			0
2. No. of positive individuals who underwent CD4 testing during the month			0
3. Total no. of target population currently on ART till the reporting month			0
4. Total no. of target population currently on treatment for TB/DOTs till the reporting month			0
Section 6 : STI/RTI Clinics			
Male		**Female**	**Total**
1. Total no. of individuals visited industry-linked clinic/govt./PPP clinics /health camps conducted by the project during the month			0
2. Of total no. who visited the health camps, no. treated for STI symptoms during the month			0
3. No. of health camps conducted by the project during the month			
Section 8 : Programme Management			
1. No. of project review meetings conducted by coordination committee during the month			
2. No. of trainings conducted during the month either by the project/SACS/any other agency as informed by SACS/STRC			
Section 9 : Human Resource			
	Male	**Female**	**Total**
1. No. of master trainers (staff trained for conducting outreach sessions) trained in the industry			0
2. Total no. of master trainers trained at the beginning of the project			0
4. Total no. of master trainers currently active			0

Annexure 20: Referral Slip for Referrals from Industries to ICTC/ ART Services

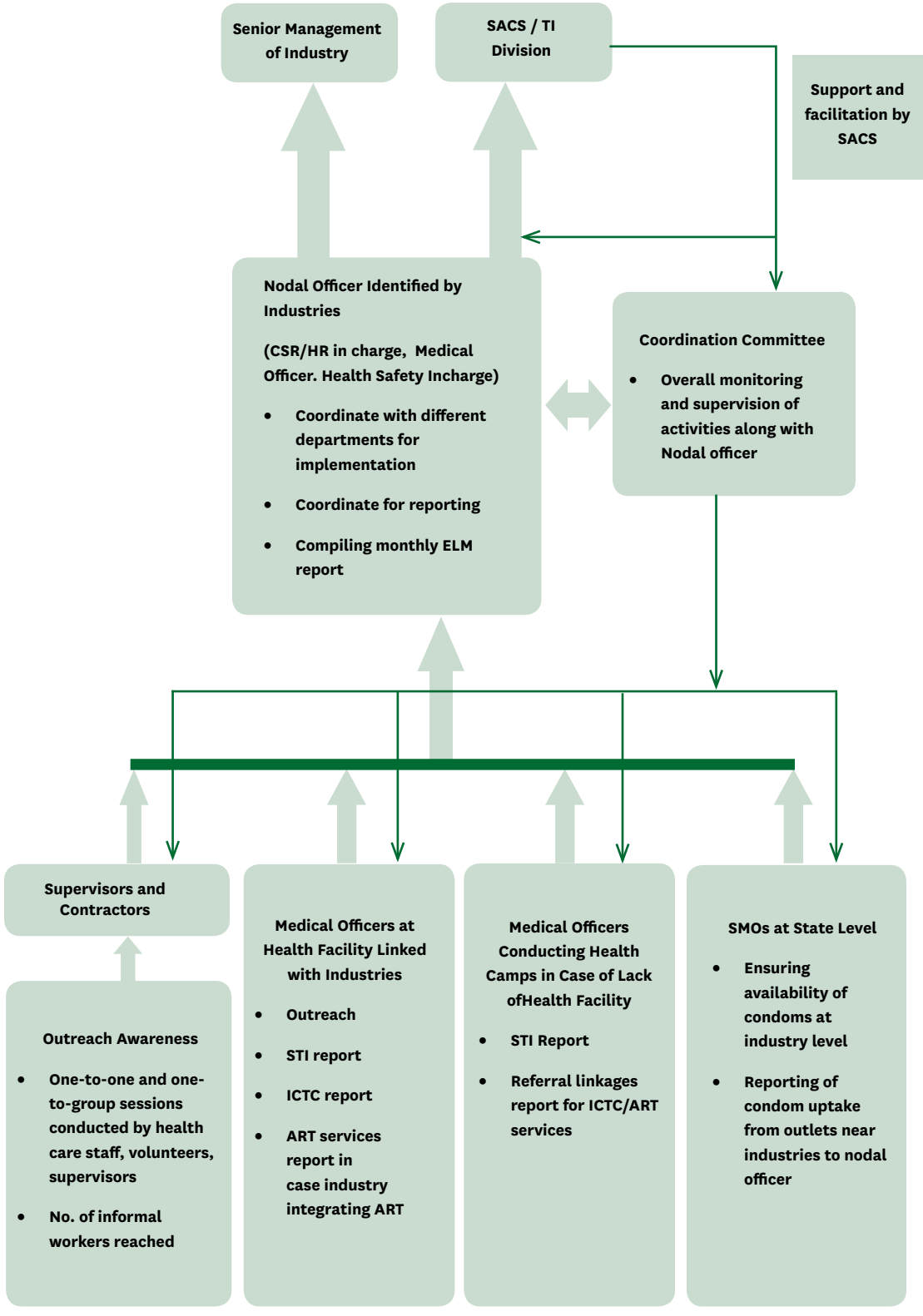
Employer-Led HIV and AIDS Intervention Model

Referral Card- Confidential

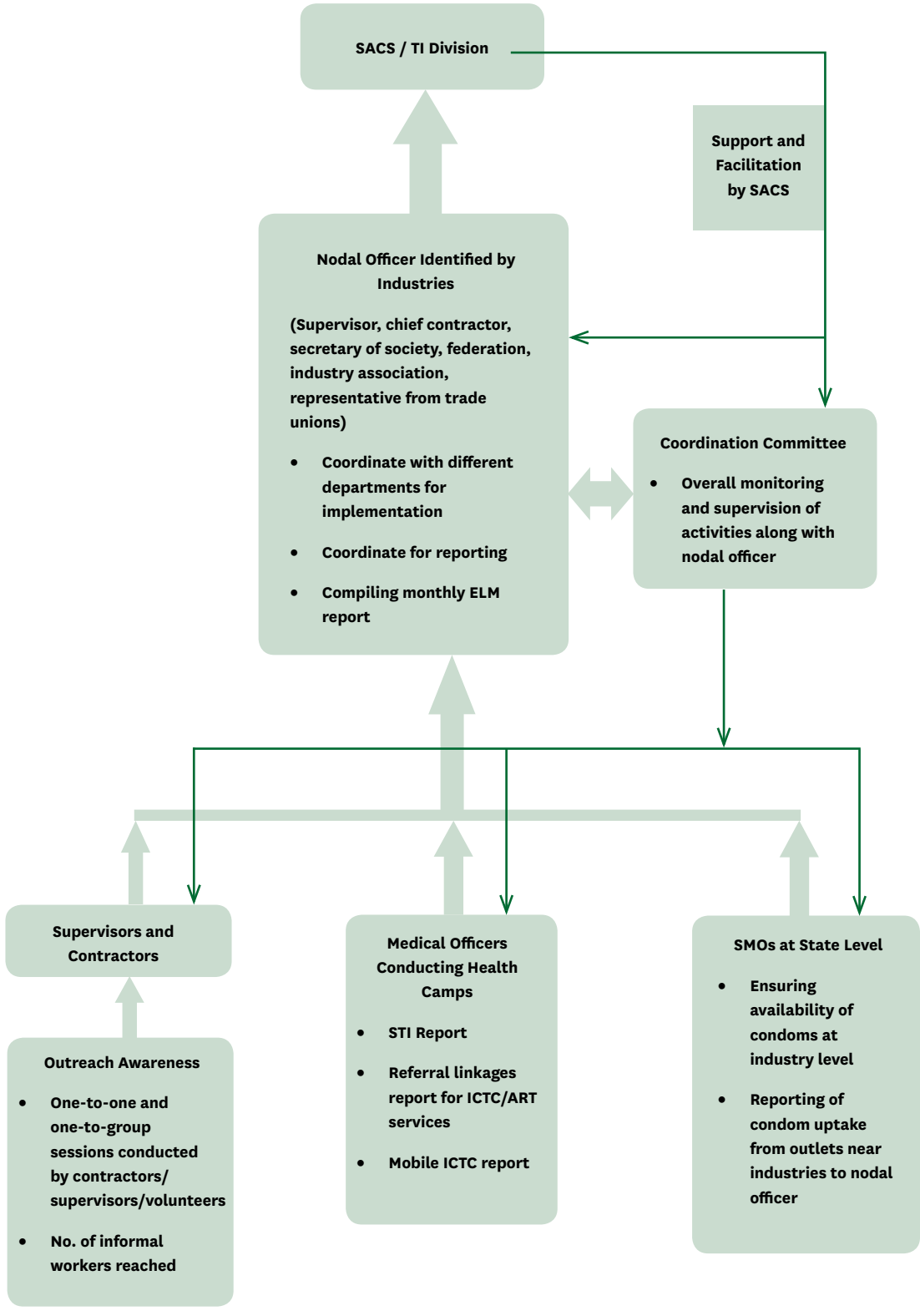
Department of AIDS Control

Name of employee being referred		Age	☐☐
Referred for (tick appropriate services)	☐ STI Diagnosis/Treatment ☐ ICTC ☐ ART ☐ PPTCT ☐ Treatment for OIs ☐ other (specify).....		
Referred to (write name and address of facility)			
Reason for referral			
Name of official issuing reference		Date of issue	☐☐☐☐☐☐
Designation		Contact number	
Name of the establishment/ industry		ELM ID	☐☐☐☐☐☐
Full address for communication			
Please accept this referral card and provide the required services. This card does not require any identity proof to be furnished along with it. Kindly contact the official issuing reference, in case you require any clarification. Employer-led HIV and AIDS Intervention is facilitated by National AIDS Control Organisation, Government of India, in partnership with select industries in India.			

Annexure 21: Data Flow Format and Monitoring and Supervision Flowchart



Unorganized Sector Industries



Annexure 22: Checklist for Mentoring and Support Visits to Industries

This checklist is to be use by the designated coordination committee -- SACS/TSU representative -- visiting the industry for supporting and mentoring visit. The aim is to provide hand-holding support to the industry for implementation of ELM. To see that all components of ELM are implemented in accordance with national guidelines (the form should be signed off by the support visit team).

Name of industry:

Date of visit:

Name of SACS/TSU representative:

Name and signature of coordination committee incharge:

Key Areas	Yes	No	Remarks
Nodal person for ELM at Industry Level			
Nodal person identified			
Nodal person oriented on ELM			
Nodal person actively participating in facilitating ELM			
Meeting with nodal person to understand issues, if any			
Functioning of Coordination Committee			
Coordination committee (CC) developed at industry			
Coordination committee oriented on ELM			
Senior management part of coordination committee			
Coordination committee meeting done once in a month			
Meeting with CC to understand issues, if any			
Awareness Activities at Industry Level			
Peer educators training completed at industry level			
Medical and para-medical staff trained at conducting awareness sessions			
IEC material available at industry			
Meeting with peer educators to understand issues, if any			
Integrated HIV/AIDS, STI Services at Industry Level			
STI Services			
Training of medical and para-medical staff completed			
STI services implemented as per guidelines			
STI drugs available at industry level			
STI camps organized on regular basis as per guidelines			

Meeting with medical officer to understand issues in implementing STI services			
ICTC Services			
ICTC services integrated within health facilities as per guidelines			
Training of health staff on ICTC services as per national guidelines			
ICTC services provided as per national guidelines			
In case of no health facility systems for referral, linkages in place			
ART Services			
ART services integrated within health facilities as per guidelines			
Training of health staff on ART services as per guidelines			
AR services provided as per national guidelines			
In case of no health facility systems for referral, linkages in place			
Condoms Promotion			
Condoms availability ensured at industry, health facilities			
Linkages established with Social Marketing Organization (SMO) for CVM or CSM near industries			
Address issues in condom availability at the industry level			
Reporting			
Nodal person coordinates and compiles monthly reporting formats			
Monthly reporting is ensured to SACS on regular basis			
Address issues in reporting and data collection at industry level			

Summary Recommendations of Mentoring and Supporting Visit

Issues	Problem Identified	Recommendations	Responsible Person
Identifying nodal person			
Coordination commitee			
Awareness activities			
Integrating HIV/AIDS, STI services			
STI services			
ICTC Services			
ART services			
Condom Promotion			
Reporting			

Annexure 23: Some Key Indicators which can be traced at Industry Level are as follows:

Type of Indicator	Key Indicators	Source of Data
Inputs	Number of health staff/contractors/ supervisors/employee volunteers trained	Monthly report
	Number of awareness sessions conducted	Monthly report
	Number of informal workers reached	Monthly report
Process	Number of coordination committee meetings occurred as per schedule	Report of CC meetings
	Services established as per DAC guideline	Mentoring and support visit reports
	Proportion of scheduled on site health camps held on time	Mentoring and support visit
	Availability of IEC, drugs, test kits as per requirement	
Outputs	Number of IEC events organised	Monthly report
	Number of condom outlets established	Monthly report
	Number of workers referred to services (ICTC, STI, etc.)	Referral records
	Number of coordination committee meetings held	CC meeting records
	Number of workers covered through IEC programmes	Monthly report
	Number of health camps/events conducted	Monthly report
Outcome	Number of workers who availed various services	Service records
	Increased awareness about HIV and AIDS among workers	KABP survey
	Reduction in stigma and discrimination towards PLHIV	KABP Survey
	Reduction in risk behaviour related to HIV and AIDS	KABP survey
	Change in company policy towards PLHIV	Policy document

Notes

Notes

National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in