

## India Report NCPI

### NCPI Header

#### COUNTRY

**Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**

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**Describe the process used for NCPI data gathering and validation:**

The India Country Progress Report was developed by the National AIDS Control Organisation-Department of AIDS Control (NACO-DAC) of India. NACO's Strategic Information Management Unit (SIMU) led the process of report development with other departments at NACO-DAC and received close cooperation of UNAIDS Country Office India. NACO adhered to a consultative process with key government officials and civil society representatives to ensure that multiple stakeholders' views and opinions were reflected in the report. Stakeholders included representatives from government departments, non-governmental organizations, the private sector, the scientific community, and academic institutions. For receiving inputs to the NCPI Part A, one-on-one interviews and discussions were held with heads of NACO-DAC departments and with government officials to receive inputs on specific thematic or programme areas. For specific input from the civil society engaged in the AIDS response to the NCPI Part B, a two step process was pursued. Under step one, the networks representing alternative and sexual minorities groups, female sex workers groups, injecting drug users groups, people living with HIV (PLHIV), women living with HIV and civil society organisations — with national, state and district level members — were approached during February – March 2012. A cascade model was used for receiving contribution from these network's national and sub-national members to the NCPI. Networks were made responsible for liaising with their respective members and receiving from them a minimum number of filled in questionnaires based on a criteria list that included (i) geographical representativeness, (ii) minority population representativeness, and (iii) knowledge on the programme. Inputs from UN, bilateral organisations and donor organisations partnering in the AIDS programme were similarly sought. Organisations were encouraged to review and individually submit the filled in questionnaire. Whilst necessary support and guidance was provided to networks and selected individuals to address queries, civil society was encouraged to independently assess progress in securing HIV prevention; treatment, care and support; human rights etc. Under step two, the approximately 50 filled in NCPI B questionnaires received from 8 networks, UN, bilateral organisations and donor organisations were analysed and consolidated at national level. Inputs received were synthesised using a specific methodology. The harmonised form that thus developed was subject to further scrutiny and discussion before it would be finally validated. All individuals who filled in and submitted the NCPI B questionnaire from states and national level representatives participated in a two day national consensus building workshop that was held on March 15-16, 2012 at national capital. The consultation encouraged maximum engagement from participation through group work exercises. Civil society representatives were encouraged to moderate discussions and achieve consensus on the NCPI without influence. To ensure neutrality, the process of receiving civil society's contribution to NCPI Part B was led by UNAIDS.

**Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**

Responses to NCPI questions were filled in through discussions and on a consensus basis.

**Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
NACO	Mr. Sayan Chatterjee, Secretary & Director General	Yes	Yes	Yes	Yes	Yes	Yes
NACO	Ms. Aradhana Johri, Additional Secretary	Yes	Yes	Yes	Yes	Yes	Yes
NACO	Dr. S. Venkatesh, DDG (M&E)	Yes	Yes	Yes	No	No	Yes
NACO	Dr.Sunil D. Khaparde,DDG( STI & LWS)	Yes	Yes	Yes	Yes	No	No

NACO	Dr. Neeraj Dhingra, DDG(TI)	Yes	Yes	Yes	Yes	No	No
NACO	Dr. R.S. Gupta, DDG(BSD)	Yes	Yes	Yes	Yes	Yes	No
NACO	Dr. Mohammad Shaukat, ADG(CST)	Yes	Yes	Yes	No	Yes	No
NACO	Dr. Sandhya Kabra, ADG (LS & BS)	Yes	Yes	Yes	Yes	Yes	No
NACO	Mr. K. Syama Prasad, JD(IEC)	Yes	Yes	Yes	Yes	No	No
NACO	Mr. R. Rajagopal, Dir (Admin. & Proc.)	Yes	Yes	Yes	Yes	Yes	No
NACO	Mr. Kanwaldeep Singh, Dir. (Fin.)	Yes	Yes	Yes	Yes	Yes	No
NACO	Dr Rajan Khobragade, Team Leader (NTSU)	Yes	Yes	Yes	Yes	No	No
NACO	Dr. BB Rewari, NPO (ART)	Yes	Yes	Yes	No	Yes	No

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
Aarthi Pai	CFAR	Yes	Yes	Yes	Yes	Yes
P Kousalya	PWN+	Yes	Yes	Yes	Yes	Yes
K Ravi Kamar	GRAPES	Yes	Yes	Yes	Yes	Yes
Laxmi	Ashodaya Samiti	Yes	Yes	Yes	Yes	Yes
Eldred Tellis	Sankalp Trust	Yes	Yes	Yes	Yes	Yes
Sylvester Merchant	Lakshya Trust	Yes	Yes	Yes	Yes	Yes
Seeta Jadav	PWN+	Yes	Yes	Yes	Yes	Yes
Asha Jahigid	PWN+	Yes	Yes	Yes	Yes	Yes
Archana Jain	PWN+	Yes	Yes	Yes	Yes	Yes
Abhu Mere	IHRN	Yes	Yes	Yes	Yes	Yes
Joe Ngamkhuchung	IPACHA	Yes	Yes	Yes	Yes	Yes
Ashok Rau	IPACHA	Yes	Yes	Yes	Yes	Yes
anis Ray Chaudhuri	Amitie Trust	Yes	Yes	Yes	Yes	Yes
B. Langkham	IPACHA	Yes	Yes	Yes	Yes	Yes
Mahesh Nathan	IHRN	Yes	Yes	Yes	Yes	Yes
Dr. Samarjit Jana	INSW	Yes	Yes	Yes	Yes	Yes
A Shankar	IHRN	Yes	Yes	Yes	Yes	Yes
A J Hari Haran	IPACHA	Yes	Yes	Yes	Yes	Yes
Ratan Kumar Ngairangbam	NCPI	Yes	Yes	Yes	Yes	Yes
Neeta Vinay	IAVI	Yes	Yes	Yes	Yes	Yes
Sunil Menon	INFOSEM	Yes	Yes	Yes	Yes	Yes
Sunil Mehra	MAMTA	Yes	Yes	Yes	Yes	Yes
Naresh Chandra Yadev	NCPI	Yes	Yes	Yes	Yes	Yes
Anil Raj Dalvi	NPM Plus	Yes	Yes	Yes	Yes	Yes
Lakshmi	PWN+	Yes	Yes	Yes	Yes	Yes
Tabitha	PWN+	Yes	Yes	Yes	Yes	Yes
Padma	PWN+	Yes	Yes	Yes	Yes	Yes
Manoj Pardesi	NCPI	Yes	Yes	Yes	Yes	Yes
Asha Ramaih	NCPI	Yes	Yes	Yes	Yes	Yes
Ivonne Camaroni	UNICEF	Yes	Yes	Yes	Yes	Yes
Taoufik Bakkali	UNAIDS	Yes	Yes	Yes	Yes	Yes
Nandini Kapoor Dhingra	UNAIDS	Yes	Yes	Yes	Yes	Yes

Nalini Chandra	UNAIDS	Yes	Yes	Yes	Yes	Yes
Shaila Bajaj	UNAIDS	Yes	Yes	Yes	Yes	Yes
-	-	No	No	No	No	No
Jahnabi Goswami	INP+	Yes	Yes	Yes	Yes	Yes
Anand Chandrani	INFOSEM	Yes	Yes	Yes	Yes	Yes
Bindu Madhav Khire	INFOSEM	Yes	Yes	Yes	Yes	Yes
Ashok Row Kavi	INFOSEM	Yes	Yes	Yes	Yes	Yes
Meana S. Seshu	INSW	Yes	Yes	Yes	Yes	Yes
Bharti Dey	INSW	Yes	Yes	Yes	Yes	Yes
Reena Chowdhury	INSW	Yes	Yes	Yes	Yes	Yes
R K Raju	IHRN	Yes	Yes	Yes	Yes	Yes
Luke Samson	IHRN	Yes	Yes	Yes	Yes	Yes

## A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

**(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):**

Yes

**IF YES, what was the period covered:**

Approximately twenty years

**IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.**

**IF NO or NOT APPLICABLE, briefly explain why.:**

The National Council on AIDS (NCA) and National AIDS Control Programme (NACP) represent the two pillars of the country's multi-sectoral strategy. The NCA is the highest forum constituted to assist the country in monitoring concerted efforts across all sections of society and through all sectors of the economy in response to the HIV epidemic. Chaired by the Prime Minister of India, the NCA is represented by 31 ministries of Govt. of India and a wide section of society: civil society, media, private industry and others. This is in addition to the directly elected Chief Ministers of high prevalence and other states in the country and Ministers of relevant government ministries. The NACP incorporates a multi-sectoral strategy to mainstream HIV to relevant government ministries and departments. A well defined strategic plan for multi-sectoral engagement was designed in the current phase III of the NACP. Under this plan, 11 key ministries were identified for mainstreaming and partnership which include the Ministries of Human Resource Development, Home Affairs, Labour, Panchayati Raj, Railways, Shipping and Surface Transport, Rural development, Tourism, Women and Child Development, Youth Affairs and Sports, and Tribal Affairs

1.1 Which government ministries or agencies

**Name of government ministries or agencies [write in]:**

Under Three Ones, the National AIDS Control Organisation (NACO), Department of AIDS Control, Ministry of Health and Family Welfare is the apex body coordinating and delivering AIDS response in India. The multi-sectoral strategy is designed and implemented in collaboration and partnership with Ministries (listed under question 1); Development partners including multi-lateral, bilateral organisations and UN, and civil society engagement.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS

**Included in Strategy**    **Earmarked Budget**

Yes	-
Yes	Yes
Yes	-

**Other [write in]:**

-

**IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure**

implementation of their HIV-specific activities?:

-

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

Yes

**Orphans and other vulnerable children:**

Yes

**People with disabilities:**

No

**People who inject drugs:**

Yes

**Sex workers:**

Yes

**Transgendered people:**

Yes

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations:**

Yes

**Prisons:**

Yes

**Schools:**

Yes

**Workplace:**

Yes

**Addressing stigma and discrimination:**

Yes

**Gender empowerment and/or gender equality:**

Yes

**HIV and poverty:**

Yes

**Human rights protection:**

Yes

**Involvement of people living with HIV:**

Yes

**IF NO, explain how key populations were identified?:**

-

**1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:**

The following key populations and vulnerable groups were identified for priority attention under the national HIV programmes: (i) the High Risk Groups of Female Sex Workers(FSW), Men who have sex with men (MSM), Transgender (TG) population and Injecting Drug Users(IDU); (ii) the bridge populations—which in India refer to single male migrants and truckers—and (iii) the general population particularly young men and women, in-school and out-of-school youth and tribals. An important focus is prevention of mother to child transmission of HIV. The care, treatment and support component of the programme provides services to PLHIV, particularly women and children. Population estimates were drawn from expert group estimations, field level mapping and site validation, development partners and stakeholders, populations requiring priority attention were identified. Targets were identified through a needs assessment—and process in continually ongoing at the national and state level in view of the rapidly changing demographics and the high mobility of many groups. Targets are determined through size estimation of HRG which was carried out at the start of NACP III. Data from mapping and sentinel surveillance, and revised size estimates are analysed to review and reprioritise geographical locations of HRG.

**1.5. Does the multisectoral strategy include an operational plan?:** Yes

1.6. Does the multisectoral strategy or operational plan include

**a) Formal programme goals?:**

Yes

**b) Clear targets or milestones?:**

Yes

**c) Detailed costs for each programmatic area?:**

Yes

**d) An indication of funding sources to support programme implementation?:**

Yes

**e) A monitoring and evaluation framework?:**

Yes

1.7

**1.7. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:**

Active involvement

**IF ACTIVE INVOLVEMENT, briefly explain how this was organised:**

Civil Society and community members are a part of the Technical Resource Groups (TRG) of NACO which are in place for each thematic area. They meet regularly to guide the programme further and provide inputs on strengthening the programme. Civil society contributed to the planning process of the next phase of National AIDS Control Programme - NACP IV - where interface was facilitated by NACO for civil society to have their voices heard. Working group discussions, regional consultations, meetings with the Planning Commission etc. were executed. Civil society has contributed to the HIV Prevention programme particularly through the Targeted Intervention projects for high risk groups of female sex workers, men having sex with men, transgender, injecting drug users and migrants and truckers. Other interventions such as Community Care Centres and Drop-in-centres for People living with HIV are also implemented through civil society organisations. Civil society played a strong role in the campaign for eradicating discriminatory laws that acted as barriers to HIV prevention, treatment, care and support efforts.

**1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:**

Yes

1.9

**1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:**

Yes, all partners

**2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:**

Yes

**2.1. IF YES, is support for HIV integrated in the following specific development plans?**

**Common Country Assessment/UN Development Assistance Framework:**

Yes

**National Development Plan:**

Yes

**Poverty Reduction Strategy:**

-

**Sector-wide approach:**

-

**Other [write in]:**

-

**2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?**

**HIV impact alleviation:**

Yes

**Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:**

Yes

**Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:**

Yes

**Reduction of stigma and discrimination:**

Yes

**Treatment, care, and support (including social security or other schemes):**

No

**Women's economic empowerment (e.g. access to credit, access to land, training):**

Yes

**Other[write in below]:**

-

**3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:**

Yes

**3.1. IF YES, on a scale of 0 to 5 (where 0 is “Low” and 5 is “High”), to what extent has the evaluation informed resource allocation decisions?:**

4

**4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as**

**military, police, peacekeepers, prison staff, etc)?:**

Yes

**5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:**

Yes

**5.1. Have the national strategy and national HIV budget been revised accordingly?:**

Yes

**5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:**

Estimates of Current and Future Needs

**5.3. Is HIV programme coverage being monitored?:**

Yes

5.3

**(a) IF YES, is coverage monitored by sex (male, female)?:**

Yes

**(b) IF YES, is coverage monitored by population groups?:**

Yes

**IF YES, for which population groups?:**

Programme coverage is monitored by sex and age group for the following population groups that receive priority attention: (i) High risk groups of Female Sex Workers(FSW), Men who have sex with men (MSM), Transgender (TG) population and Injecting Drug Users(IDU); (ii) the bridge population groups of single male migrants and truckers and (iii) the general population particularly antenatal clinic attendees and youth.

**Briefly explain how this information is used:**

The HIV epidemic in India is dynamic with trends varying at national , regional , state and district level by population groups and place of residence. Tailoring the programme to meet the local requirements and respond to the epidemic's trajectory at the micro level is considered pivotal to India's AIDS response strategy. Such an approach also enables more effective and efficient resource utilisation. Along with epidemiological data, programme monitoring data generated through Computerised Management Information System provides pertinent information on specific programme indicators.

Programme data is monitored according to a set of dashboard indicators - at the output level - on a quarterly and annual basis by NACO at national level, SACS at the state level and DAPCUs at the district level with communication and feedback flowing two ways. Programme monitoring data is utilised for (i) assessing progress in programme implementation and advancements made at the national and sub-national level in reaching specific targets. (ii) Identifying bottlenecks and undertaking necessary course corrective measures for overcoming them. (iii) Programme planning at state level and formulation of costed state Annual Action Plans.

**(c) Is coverage monitored by geographical area:**

Yes

**IF YES, at which geographical levels (provincial, district, other)?:**

Programme coverage data is monitored at the national, state,district and reporting unit/service delivery point levels. (iv) Triangulation of data for better understanding of HIV epidemic & vulnerabilities.

**Briefly explain how this information is used:**

With latest HIV epidemiological data reflecting on the diversity of the epidemic at the sub-national levels, monitoring the programme by geography is essential for (i) appropriately formulating programme interventions, (ii) assessing progress in achieving targets in states and districts and measuring results, (iii) future planning and formulating costed Annual Action Plans.

**5.4. Has the country developed a plan to strengthen health systems?:**

Yes

**Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:**

Strengthening health systems - particularly HIV related infrastructure, logistics system, and human resource capacities - is in built to the national programme. NACO has also scaled up Opioid Substitution Therapy (OST) for Injecting Drug Users. This has been done in Public Health Settings and hospital staff have been trained on drug-related issues and treatment options. This has facilitated the linkage of targeted intervention sites to hospital settings. Joint guidelines & operating mechanism has been developed in close collaboration with National Rural Health Mission in the areas of STI, Care & Treatment, condom Promotion, blood safety & PPTCT. Through the findings from the annual programme Joint Implementation Review Missions and programme evaluations conducted at the national and sub-national level, initiatives were undertaken for strengthening the HIV related infrastructure. With development partners, some of the key procurements for strengthening programme implementaiton infrastructure include CD4 count machines, blood bank equipments, test kits etc. Efforts were made for streamlining the Supply Chain Management (SCM) of various supplies to consuming units at the state and district levels and this includes training on SCM, placing Procurement and Logistics coordinators for groups of SACS etc. The National AIDS Programme has prioritised human resource capacity building for enhancing technical and managerial capabilities required for efficient programme implementation and planning. NACO with development partners has developed standardised curriculum, modules and tool kits. Innovative approaches were adopted for facilitating learning for example use of e-learning modules, video conferencing, e-group discussions etc. Between April and December 2011, over 500,000 personnel were received training on various programme components including blood safety, counselling, care-support-treatment, STI, link worker scheme, Targeted Interventions, M&E and Strategic Information etc.

**6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:**

**Since 2009, what have been key achievements in this area:**

Achievements included in the Annual Report of department of AIDS Control

**What challenges remain in this area:**

-

**A - II. POLITICAL SUPPORT AND LEADERSHIP**

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

**A. Government ministers:**

Yes

**B. Other high officials at sub-national level:**

Yes

1.1

**(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):**

Yes

**Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:**

India's political leadership at the highest level, starting from India Prime Minister and notably including India Minister of Health and Family Welfare, undertook particular steps for keeping AIDS response high on the political and development agenda of the country; and committing to all its citizens continued effort for ensuring Universal Access to HIV prevention, treatment, and care and support services. The initiatives included firstly, the active commitment made by Indian delegates at the June 2011 High Level meeting on HIV/AIDS for AIDS response. Secondly, strengthened commitment of elected representatives' to support prevention of new HIV infections and address community level stigma and discrimination. Thirdly, government sanction of ensuring availability of quality generic medicines, including ART. A brief description on each of the above is presented below. (1) Commitment for effective AIDS response at the June 2011 High Level meeting on HIV/AIDS: With 192 countries coming together in New York on June 8-10, 2011 at the High Level Meeting on HIV/AIDS; India seized opportunity to reaffirm at this global platform its national commitment to increase efforts for delivering Universal Access to all its citizens. The Indian delegation — led by India Minister of Health and Family Welfare, Chairman on Human Resource Development and President of Forum of Parliamentarians on AIDS (FPA), Member of Parliament and Secretary General FPA, Secretary and Director General NACO-DAC, Additional Secretary NACO-DAC and included senior officials and over a dozen civil society representatives — engaged in high level dialogue to (i) learn from other countries' best practise examples, (ii) highlight the key national strategies pursued for achieving HIV/AIDS roll back under NACP III and (iii) commit to re-doubling efforts in the strive to achieve newly agreed targets under the 2011 Political Declaration on HIV/AIDS. India, a country successful in achieving Millennium Development Goal 6 well in advance of its timeline, credited its focused and intensive HIV prevention programme for containing the epidemic and preventing annual new HIV infections by 56% over the previous decade (2000-2009). With India at the threshold of NACP IV, Minister of Health and Family Welfare highlighted India's approach for preventing new infections and assured that treatment access would be strengthened and new interventions introduced in cost effective manner. India took opportunity of making two commitments before the global community at the High Level Meeting. Firstly, that domestic funding for HIV/AIDS would be increased to ease the resource gap. Secondly, that India recommended use of the flexibility in TRIPS for ensuring affordable life saving medicines, including ART, for all. The collective efforts of the global community would be required nevertheless for ensuring treatment access for all those who require it. (2) India's political leaders confirmed their support for prevention of HIV and facilitate access to care, support and treatment without stigma and discrimination against PLHIV at the community level: Multiple initiatives were conducted for sensitising elected representatives at the national, state, district and sub-district levels on (i) the impact of the HIV epidemic on health and other key sectors and (ii) to emphasize the role of elected representatives in national AIDS response and garnering their greater support. The key activities that have resulted in greater support from the elected representatives for AIDS response are detailed below. (2.1) Pledge by Parliamentarians, Legislators, Zilla Parishad Chairpersons and Mayors to sustain support for HIV/AIDS at National Convention: A two day national consultation was executed in July 2011 through the collaborative effort of Ministry of Health and Family Welfare, Forum of Parliamentarians on AIDS and UNAIDS. The national convention was addressed by the Prime Minister of India who led the call for strengthening local responses and increasing coordination. Senior delegates and members of the union Cabinet who addressed the participants included the Chairperson of the United Progressive Alliance, Speaker of the Lok Sabha, Leader of the Opposition, Deputy Chairman of the Planning Commission, Union Minister of Health and Family Welfare and Union Rural Development Minister. Key points raised at the convention include, the need for India to sustain its focus on AIDS response considering that approximately 2.4 million people are living with HIV in India. It re affirmed the need to continue its focus on prevention of HIV while ensuring accessibility of care, support and treatment to all specially women and children. It also reiterated that the program needs to ensure Universal access to HIV services by reducing stigma and discrimination against people living with HIV and other vulnerable groups. The convention stressed that HIV is not only a health issue as it requires a holistic approach which would cater to the social, economic and legal requirements of PLHIV. The convention did sensitize 500 Parliamentarians, Legislators, Zilla Parishad Chairpersons and Mayors on current issues of HIV in urban and rural areas and their role in the issue of HIV/AIDS. The elected representatives also drafted a note on their role in reducing Stigma and Discrimination against PLHIV and vulnerable groups. The Prime

Minister also committed more domestic funds for NACP in the next phase. 2.2) State level initiatives for strengthening elected representatives' engagement in AIDS response: India views the participation of political leadership vital for sustained HIV response. Political leaders — including Members of Parliament, State Legislative Assemblies and other national and state level political leaders — play a critical role in creating an enabling environment, reducing HIV/AIDS related stigma and discrimination at the community level, and increasing HIV/AIDS awareness. India has several forums where leaders from across all political parties and other stakeholders come together and support national and state initiatives. These are the Forum of Parliamentarian on HIV/AIDS (FPAs) and state Legislative Forum on HIV/AIDS (LFAs). LFAs are established in 12 states of India and it re-affirms the commitment (i) by the respective state level political leaders to support in ensuring accessibility to prevention services, care, support and treatment at the grass root level and (ii) facilitate jointly to reduce stigma and discrimination against PLHIV and other vulnerable groups in the community (2.3) Sensitisation of local self government representatives including Mayors, Deputy Mayors, Municipal Counsellors and Municipal Commissioners on AIDS: The Forum of Parliamentarians on HIV/AIDS (FPA) and the All India Institute of Local Self Government (AIIILSG) organised a special session on HIV during the International Conference on Local Self Government at Kerala from April 22 - 25, 2011. Over 100 elected representatives from Indian municipalities and Asian municipalities participated in the event. The session discussed issues related to HIV/AIDS and in particular the strategy of national programme, challenges and opportunities for partnerships. Participants endorsed a declaration to reaffirm their commitment in AIDS response at the conference. (3) Commitment for sustaining availability of quality generic drugs, including antiretroviral drugs: India is currently the largest supplier of generic medicines to the developing world apart from having an ever expanding market. Indian generic medicines have ensured that life-saving medicines were made available to the poor people in India, the African continent and in South America at very affordable prices; a practise that the Government is keen on sustaining. India's ability to provide low-cost generic medicines was predominately due to its intellectual property laws — specifically, pre-TRIPS (Trade-related aspects of Intellectual Property Rights) and presently TRIPS-compliant patent law — which allowed for local generic production of safe and efficacious medicines. The free trade agreement (FTA) under negotiation between India and the European Union had threatened production of generic medicines. With millions in the developing world dependent on India for generic medicines at affordable costs — particularly antiretroviral (ARVs) — Indian political leadership was aware that a restriction of generic drug production in India would have a devastating public health impact around the world and adversely affect the right to health of millions of people. The government, thus, has continued to resist any clauses in FTA negotiations that limit generic manufacturers' ability to supply quality low-cost medicines to Indian citizens and to the millions of people around the world. Under leadership of India Minister of Commerce, a consultative committee of the Parliament on challenges in Intellectual Property Rights was established to oversee this. India does not provide data exclusivity for pharmaceuticals which is in the paramount interest of generic pharmaceutical industry as grant of data exclusivity would have considerable impact in delaying the entry into the market of cheaper generic drugs. India aims to continue the pro-active steps and maintain the current status in ensuring seamless access to ART, other drugs, and vaccines to people in India and other developing countries. India recognised that the BRICS countries — Brazil, Russia, India, China and South Africa — face similar health challenges, have inequitable access to health services and growing health care costs. Through collective action and influence, the BRICS coalition could deliver cost-effective, equitable and sustainable solutions for global health. With this rationale, an alliance to the effect was forged when the Ministers of Health from the five BRICS countries issued and signed the Beijing Declaration July 11, 2011. The Beijing Declaration underscored the importance of technology transfer among the BRICS countries, as well as with other developing countries, to enhance their capacity to produce affordable medicines and commodities. The Declaration also emphasized the critical role of generic medicines in expanding access to antiretroviral medicines for all. By signing the Declaration, leaders committed to working together to preserve the provisions contained in the Doha Declaration on TRIPS and Public Health — provisions that allow for countries to overcome intellectual property rights restrictions on medicines in the interest of public health. India is committed to Universal Access to treatment at the highest political level and considered a best practise. (4) Social Protection needs for the PLHIVs include food security, nutritional security, health security, housing security, employment security, income security, life and accident security and old age security. National AIDS Control Programme in India has been focusing on Social protection by improving access of the PLHIVs to several of the existing schemes in an attempt to reduce their vulnerabilities. Efforts have been made to change and include PLHIVs within the existing schemes as well as to initiate new exclusive schemes. Currently 35 central and state level schemes have been modified for PLHIV and 29 state directives have been issued by State Councils on AIDS to aid the PLHIVs.

**2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:**

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

**Have terms of reference?:**

Yes

**Have active government leadership and participation?:**

Yes

**Have an official chair person?:**

Yes

**IF YES, what is his/her name and position title?:**

Mr. Manmohan Singh, India Prime Minister is Chair person of the National Council on AIDS (NCA).

**Have a defined membership?:**

Yes

**IF YES, how many members?:**

-

**Include civil society representatives?:**

Yes

**IF YES, how many?:**

53

**Include people living with HIV?:**

Yes

**IF YES, how many?:**

2

**Include the private sector?:**

Yes

**Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:**

Yes

**3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:**

Yes

**IF YES, briefly describe the main achievements:**

The National Council on AIDS (NCA) is the apex body on HIV and AIDS in the country and is chaired by the Prime Minister of India. It therefore meets as necessary or in times of special need. NACO which is Indian equivalent of a National AIDS Commission is the secretariat of NCA. It manages donor coordination through a steering committee which meets regularly on a quarterly basis. The estimation of extra-budgetary funding from donors for the National program was carried out in November 2009 at the mid-term evaluation of the program. Additionally, NACO regularly review actions on policy decisions, actively promotes policy decisions, and provides opportunity for civil society to influence decision-making. Example, active civil society engagement in NACP IV development. NACO is deeply engaged with approval of donor organisations' work plans. This is for harmonizing their activities with those carried out under budgetary sources of financing. There is also a move to institutionalize the concept of a 'lead donor' for each state of India. As a result of these mechanisms, the following are established by NACO : 1. The Targeted Intervention programme working with MARPS is implemented by NGOs and CBOs. 2. Community and civil society groups were consulted and involved in development of training modules, guidelines and policies. 3. The private sector has been engaged in enhancing interventions for Migrants and Truckers. 4. Private sector representatives are part of working groups for future programme planning

**What challenges remain in this area:**

-

**4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:**

35%

5.

**Capacity-building:**

Yes

**Coordination with other implementing partners:**

Yes

**Information on priority needs:**

Yes

**Procurement and distribution of medications or other supplies:**

Yes

**Technical guidance:**

Yes

**Other [write in below]:**

-

**6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:**

Yes

**6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:**

No

**7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?:**

9

**Since 2009, what have been key achievements in this area:**

The political support for the National Programme is high. As highlighted in response to question 1.1 above, India's political leadership at the highest level, starting from India Prime Minister, undertook particular steps for keeping AIDS response high on the political and development agenda of the country; and committing to all its citizens continued effort for ensuring Universal Access to HIV prevention, treatment, and care and support services. The initiatives included firstly, the active commitment made by Indian delegates at the UN General Assembly June 2011 High Level meeting on HIV/AIDS for AIDS response. Secondly, strengthened commitment of elected representatives' to support prevention of new HIV infections and address community level stigma and discrimination. At the July 2011 National Summit for Parliamentarians, Legislators, Zilla Parishad Chairpersons and Mayors on HIV/AIDS, the over 500 political leaders and representatives present pledged to sustain support for HIV/AIDS at National Convention. Thirdly, reaffirmation by the government of India to ensure that quality generic medicines, including antiretroviral (ARV) drugs, were seamlessly available in India and to all countries. The Joint Parliamentary Forum on

AIDS at national level and State Legislative Forums on AIDS over a third of the states actively provide political support. It is envisioned that in future the politicians would set the agenda for HIV/AIDS and subsequently mobilize the public.

**What challenges remain in this area:**

## A - III. HUMAN RIGHTS

1.1

**People living with HIV:**

No

**Men who have sex with men:**

No

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs:**

No

**Prison inmates:**

No

**Sex workers:**

No

**Transgendered people:**

No

**Women and girls:**

Yes

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in]:**

-

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**

Yes

**IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:**

The Constitution of India provides protection to all citizens—irrespective of age, gender, caste and class - to constitutional safeguards against discrimination. This covers PLHV on matters of public employment and to some extent health care. Fundamental Rights enshrined in the Constitution of India are guaranteed to all citizens and form primary basis for protecting rights of people living with HIV and AIDS (PLHV):  Article 14 Equality before law  Article 15 Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth  Article 16 Equality of opportunity in matters of public employment  Article 21 Protection of life and personal liberty  Article 21A Right to Education India has non-discrimination laws for protecting rights and interests of women and children. These are through Articles 15 and 16 of the Indian Constitution and the Juvenile Justice Act. The reading down of Section 377 by Delhi High Court which decriminalises adult consensual sex in private has paved way for inclusion of sexual minorities within the anti discriminatory framework of the Constitution. Certain State Governments have introduced initiatives for marginalised / vulnerable populations' welfare. For example the measures by the Aravani Board—set up by Tamil Nadu government—for protecting the transgender population and looking at their welfare through ration cards and housing schemes. Similar schemes are in consideration in a few other states.

**Briefly explain what mechanisms are in place to ensure these laws are implemented:**

The judiciary is to ensure that the constitution is implemented. In case of infringement of these fundamental rights, citizens have the right to move the Supreme Court under Article 32 (1) of the Constitution of India. The High Court and Supreme Court can accordingly issue directions, orders or writs against violations of Constitutional rights under Article 32 (2) of the Constitution of India. The National and State Human Rights Commissions; National and State Commission for the Protection of Child Rights; Press Council of India; National and State Commission for Women monitor violations of the rights and direct appropriate remedy. Government policies such as the National AIDS Prevention and Control Policy (NAPCP) 2002 espouse a human response and highlight the need for involvement of most at risk populations such as FSW, MSM, TG and IDU.

**Briefly comment on the degree to which they are currently implemented:**

India is implementing harm reduction for injecting drug users to ensure that even such marginalized populations have access to healthcare and are free from discrimination. Further, groups such as sex workers and MSM are encouraged to collectivize and also linked to public health services. NACO has piloted innovative approaches for working with female injecting drug users, spouses and widows of injecting drug users. At the ground level, TI projects conduct advocacy with the police and other key stakeholders to ensure that they too are aware of the rights and privileges of groups that are marginalized.

**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**

Yes

IF YES, for which subpopulations?

**People living with HIV:**

No

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs :**

Yes

**Prison inmates:**

Yes

**Sex workers:**

Yes

**Transgendered people:**

Yes

**Women and girls:**

No

**Young women/young men:**

No

**Other specific vulnerable subpopulations [write in below]:**

-

**Briefly describe the content of these laws, regulations or policies:**

Provisions of the following Acts continue to be obstacles for reaching most at risk populations and in some cases result in violence and harassment • Men who have sex with men: Section 377 of the Indian Penal Code considers unnatural or carnal intercourse against the order of nature which includes non – penile vaginal sex between man and woman, man and man and man with animal and criminalizes the same with punishment of up to 10 years. The reading down of Section 377 by Delhi High Court in July 2009 decriminalized consensual sex between adults encouraging the men having sex with men (MSM). However, this judgment is currently being challenged in the Supreme Court of India. Injecting drug users- The Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 lays out a framework for drug control and proscribes production, cultivation, manufacture, sale, possession and consumption of cannabis, opium, cocaine and other psychotropic substances as illegal. The NDPS is strongly enforced. People who use drugs tend to be arrested for consumption and/or possession of drugs even if in small quantities. Both are punishable offences with a jail term of 6 months to 1 year depending on the drug. Although the Act allows persons dependent on drugs to receive treatment. It threatens harm reduction programmes of needle syringe provision with prosecution for “abetment”. Sex Workers: The Immoral Traffic (Prevention) Act 1956 or ITPA regulates sex work while penalizing trafficking or procurement and detention in organised sex work. The Act bestows the police with special powers for arresting sex workers and raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. These raids, however, drive sex workers underground. This inhibits their access to health care and or preventive interventions.

**Briefly comment on how they pose barriers:**

Men who have sex with men: Section 377 of the Indian Penal Code considers unnatural or carnal intercourse against the order of nature which includes non – penile vaginal sex between man and woman, man and man and man with animal and criminalizes the same with punishment of up to 10 years. This restricts MSM from revealing their identity and accessing health care services. Injecting drug users- The Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 threatens harm reduction programmes of needle syringe provision with prosecution for “abetment”. Sex Workers: The Immoral Traffic (Prevention) Act 1956 or ITPA regulates sex work while penalizing trafficking or procurement and detention in organised sex work. The Act bestows the police with special powers for arresting sex workers and raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. These raids, however, drive sex workers underground. This inhibits their access to health care and or preventive interventions.

**A - IV. PREVENTION****1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:**

Yes

IF YES, what key messages are explicitly promoted?

**Abstain from injecting drugs:**

Yes

**Avoid commercial sex:**

Yes

**Avoid inter-generational sex:**

Yes

**Be faithful:**

Yes

**Be sexually abstinent:**

Yes

**Delay sexual debut:**

Yes

**Engage in safe(r) sex:**

Yes

**Fight against violence against women:**

Yes

**Greater acceptance and involvement of people living with HIV:**

Yes

**Greater involvement of men in reproductive health programmes:**

Yes

**Know your HIV status:**

Yes

**Males to get circumcised under medical supervision:**

-

**Prevent mother-to-child transmission of HIV:**

Yes

**Promote greater equality between men and women:**

Yes

**Reduce the number of sexual partners:**

Yes

**Use clean needles and syringes:**

Yes

**Use condoms consistently:**

Yes

**Other [write in below]:**

-

**1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:**

Yes

**2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:**

Yes

2.1. Is HIV education part of the curriculum in \_\_\_\_\_

**Primary schools?:**

No

**Secondary schools?:**

Yes

**Teacher training?:**

Yes

**2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:**

Yes

**2.3. Does the country have an HIV education strategy for out-of-school young people?:**

Yes

**3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:**

Yes

**Briefly describe the content of this policy or strategy:**

-

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address? \_\_\_\_\_

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
Yes	Yes	Yes	Yes	No	migrants and truckers
Yes	No	No	No	Yes	-
Yes	Yes	Yes	Yes	Yes	migrants and truckers
Yes	No	No	No	Yes	-
Yes	Yes	Yes	No	Yes	migrants and truckers
Yes	Yes	Yes	No	No	migrants and truckers
Yes	Yes	Yes	Yes	No	migrants and truckers
No	No	No	No	No	-

**3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?:**

9

**Since 2009, what have been key achievements in this area:**

The policy efforts in support of HIV prevention have been critical to India's AIDS response. HIV prevention is a central strategy of India's NACP III with specific focus awarded to the higher risk groups of female sex workers, injecting drug users, men having sex with men and the bridge population groups of migrants and truckers. From the private sector, some organizations have come forward and are partnering with SACS such as in Gujarat to undertake migrant interventions through a public-private partnership where SACS provides Technical Support inclusive of Capacity Building and materials required such as IEC and the organization caters to the migrant population in its geographical reach through its own human resource and initiatives. Similarly in Truckers intervention, while we have liaised with NGOs and Associations, Organizations in the industry have also stepped forth to adapt our approach in their workplace. Here too SACS partners in terms of Technical Support and in procurement initiatives such as in IEC, setting up of clinics and so on, followed by vulnerable population of women and youth. The assessment of the Targeted Intervention projects in India for HIV prevention point to its positive effect in preventing HIV acquisition and HIV transmission. Behaviour change communication with most at risk populations led to increased health seeking behaviour and increased access to testing and treatment services. Service delivery in terms of condom promotion and distribution of commodities were also implemented with careful monitoring and supervision. Civil society has played a central role in implementing Targeted Intervention projects for HIV prevention. The number of integrated counseling and testing centers (ICTC) has also been scaled up in recent years which has easier access. STI preventive essential service facilitated packages were provided to the HRG community for preventing HIV and STI infection resulting in reduction of HIV and reproductive morbidity in them. The prevention of parent to child transmission programme (PPTCT) was also scaled up to prevent vertical transmission of HIV and increase mother baby pair coverage with an aim of achieving the target of zero new infections through perinatal transmission. High quality training modules have also been developed with focus on human resource capacity development. A robust SIMS system is also established. Red Ribbon Express (RRE) is the world's largest mass mobilization campaign on HIV/AIDS. It is a special exhibition train which travels across the country disseminating the messages on HIV/AIDS and general health in rural and remote areas of the country. Along with the train special outreach programmes are organized in the villages through IEC exhibition vans and folk troupes. The project received overwhelming response all across the country- 8 million persons were reached, and 81,000 district resource persons were trained. The third phase of campaign has been launched on 12 January, 2012 on the occasion of National Youth Day. Keeping the higher vulnerability of youth to HIV, the third phase focuses on youth. A special coach is designed to address youth specific issues in an interactive and youth friendly manner. The RRE has reached out to people in rural and remote areas and has also been successful in generating political support and will, across the parties, for HIV/AIDS programme. National AIDS Control Programme has extensively used the folk media as an innovative tool for developing an effective communication package to reach the unreached in the rural, remote and media dark areas. The campaign focusing on women and youth implemented in two phases across 476 districts of 24 states. Nearly 30,330 performances could reach about 0.5 million people with messages on HIV transmission, prevention, care, support, treatment, HIV testing, PPTCT, stigma & discrimination. The immediate impact was a spurt in queries especially from women for further information on HIV/AIDS and on testing facilities, and increased access to ICTCs. Outdoor campaigns are conducted through Hoardings, Bus Panels, Kiosk, wall painting wall writings, auto panels, panels in metro trains and railway stations. it is an important activity to increase visibility. To implement this effectively a composite outdoor plan is developed in partnership with State AIDS Control Societies, Condom Social Marketing Organizations (SMOs) and other development partners in sync with the national mass media calendar. Link Worker Scheme is a rural-based intervention for prevention and care needs of High Risk Groups (HRGs) and vulnerable population of rural areas including referral to ICTC services and STI services, Condom promotion & distribution, information related to HIV prevention and related services. Link Worker Scheme is currently functional in 153 districts. The Scheme covered about 1,22,701 HRG, 8,99,130 Vulnerable Population and 34,033 PLHIV during 2011-12. Nearly 59% HRGs have been tested at ICTC and 58% HRGs have been referred to STI services under this intervention. This has been done by establishing linkages with existing services. In order to create a sense of ownership in the community and involve the youth in fighting against HIV, 13,296 Red Ribbon Clubs and 21,170 Information Centres had been established at the village level by March, 2012. Access to safe blood has been ensured through around 1,149 blood banks supported by NACO which include 171 Blood Component Separation Unit and 28 Model Blood Banks. During the year 2011-12, 9.3 million blood units were collected across the country of which 5.1 million units were collected through NACO supported Blood Banks; 83.5% of blood collected in NACO supported Blood Banks was through Voluntary Blood Donation.

**What challenges remain in this area:**

Following are some of the challenges: 1. Certain low prevalence states and districts showing rising trends, larger share of new HIV infections and higher vulnerabilities due to - Migration to high prevalence areas, increasingly being identified as an important factor driving the epidemic in several north Indian districts - Emerging epidemics related to MSM, Transgenders, IDU & young sex workers 2. States with emerging epidemics are those with relatively poor health infrastructure & weak implementation capacities, governance and ownership of the program 3. Need to consolidate successes gained by sustaining prevention focus besides effectively addressing emerging issues 4. Major challenge for the programme will be to ensure that the treatment requirements are fully met without sacrificing the needs of prevention 5. Convergence with National Rural Health Mission

**4. Has the country identified specific needs for HIV prevention programmes?:**

-

4.1. To what extent has HIV prevention been implemented?

**Blood safety:**

Agree

**Condom promotion:**

Agree

**Harm reduction for people who inject drugs:**

Agree

**HIV prevention for out-of-school young people:**

Agree

**HIV prevention in the workplace:**

Agree

**HIV testing and counseling:**

Agree

**IEC on risk reduction:**

Agree

**IEC on stigma and discrimination reduction:**

Agree

**Prevention of mother-to-child transmission of HIV:**

Agree

**Prevention for people living with HIV:**

Agree

**Reproductive health services including sexually transmitted infections prevention and treatment:**

Agree

**Risk reduction for intimate partners of key populations:**

Agree

**Risk reduction for men who have sex with men:**

Agree

**Risk reduction for sex workers:**

Agree

**School-based HIV education for young people:**

Agree

**Universal precautions in health care settings:**

Agree

**Other[write in]:**

-

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:

9

## A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:

Yes

**If YES, Briefly identify the elements and what has been prioritized:**

The comprehensive package of HIV treatment, care and support services were identified through a consultative process with stake holders, development partners and technical resource group. The services have continually been updated and expanded based on the current requirements and feedback received through assessments and reviews etc. The aim is achieving Universal Access first line and second line ART for adults and children; scaling up service centers for ART provision; maintaining a high level of drug adherence and minimizing the number of patients lost to follow up; and, providing comprehensive care, support and treatment at the district and sub-district levels.

**Briefly identify how HIV treatment, care and support services are being scaled-up?:**

As stated previously, The HIV Care, Support and Treatment services are updated and expanded continually based on the current requirements and feedback received through assessments and reviews. Effective oversight and guidance to the Care Support and Treatment programme is provided by the Technical Resource Groups (TRG) at the national level with NACO. The TRGs comprised of a group of experts who reviewed progress in programme implementation, and provided technical inputs, suggestion and recommendations on various technical and or operational issues relating to the programme. Meetings of TRGs were held periodically with clearly drawn agenda and issues for discussion. Following were the TRGs inputting to the CST programme: (i) TRG on ART, (ii) TRG on Paediatric HIV, (iii) TRG on Community Care Centres, and (iv) National HIV drug resistance committee. TRG meetings were held at least once a year, if not earlier to address specific items. Under their oversight, effective delivery of the CST programme is enabled. • Care, Support & Treatment Programme provides prevention and treatment of opportunistic infections, Anti-Retroviral Therapy, psychosocial support, home based care, positive prevention and impact mitigation. During the last 3 years, there has been significant up scaling of Care, Support & Treatment activities in terms of the number of ART centres, number of patients registered and number of patients on-ART. Under the Care, Support and Treatment Programme, the number of Anti-Retroviral Therapy (ART) centres has been scaled up from 127 in 2007-08 to 355 in March 2012. In addition, there are 725 Link ART Centres. There are 5.16 lakh PLHIV on first line ART and 4,208 PLHIV on second line ART treatment. For providing treatment and care to HIV infected children, National Paediatric HIV/AIDS initiative in November 2006. Since then, 28,000 HIV infected children are receiving free ART.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**

Agree

**ART for TB patients:**

Agree

**Cotrimoxazole prophylaxis in people living with HIV:**

Agree

**Early infant diagnosis:**

Agree

**HIV care and support in the workplace (including alternative working arrangements):**

Agree

**HIV testing and counselling for people with TB:**

Agree

**HIV treatment services in the workplace or treatment referral systems through the workplace:**

Agree

**Nutritional care:**

Agree

**Paediatric AIDS treatment:**

Agree

**Post-delivery ART provision to women:**

Agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**

Disagree

**Post-exposure prophylaxis for occupational exposures to HIV:**

Agree

**Psychosocial support for people living with HIV and their families:**

Agree

**Sexually transmitted infection management:**

Agree

**TB infection control in HIV treatment and care facilities:**

Agree

**TB preventive therapy for people living with HIV:**

Agree

**TB screening for people living with HIV:**

Agree

**Treatment of common HIV-related infections:**

Agree

**Other [write in]:**

-

**2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:**

No

**Please clarify which social and economic support is provided:**

Social Protection needs for the PLHIVs include food security, nutritional security, health security, housing security, employment security, income security, life and accident security and old age security. National AIDS Control Programme in India has been focusing on Social protection by improving access of the PLHIVs to several of the existing schemes in an attempt to reduce their vulnerabilities. Efforts have been made to change and include PLHIVs within the existing schemes as well as to initiate new exclusive schemes. Currently 35 central and state level schemes have been modified for PLHIV and 29 state directives have been issued by State Councils on AIDS to aid the PLHIVs. The numerous needs assessment exercises undertaken by civil society clearly points to the need for HIV impact mitigation as a key strategy for securing a livelihood for people living with HIV. National and state governments have introduced various measures aimed at enabling a conducive environment for people infected and affected with HIV to access transportation for treatment adherence, subsidies on certain food items such as wheat and rice, nutrition supplements for children, financial assistance for positive people on ART, income generation etc. with special focus on the poor and marginalised populations. To ensure that the social protection schemes introduced are utilised and made beneficial to the target population, a study was undertaken to firstly, assess the use of social protection schemes by people living with HIV and secondly, identify the efforts, opportunities and challenges experienced by people living with HIV in the utilization of various schemes. Based on the key findings emerging from the state level study, larger discussions were held on barriers to access at the national level. The scope and possibility of NGO/CSO/PLHIV Network led models of livelihoods promotion was assessed and strategies for livelihood promotion - that best suited the needs of people infected and affected with HIV - was assessed through another study. Findings from these initiatives collectively feed to the NACP IV that carefully considers the needs, aspirations and requirements of people living with HIV.

**3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:**

Yes

**4. Does the country have access to regional procurement and supply management mechanisms for critical**

**commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:**

Yes

**IF YES, for which commodities?:**

All ARV drugs are procured annually following with international competitive bidding procedures. Following technical and financial evaluation the successful bidders are placed the order after concurrence from the Ministry of Health & Family Welfare. The drugs are supplied directly to ART Centres by suppliers in two instalments. Each is of 50% quantity at 6 month interval. A supply chain management unit at NACO gets drug stocks and consumption reports from all facilities monthly. This is then compiled centrally. Centres with shortages/excess drugs/near expiry drugs get these drugs relocated through courier. The supply chain management unit is facilitated by the Clinton Foundation.

**5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:**

9

**Since 2009, what have been key achievements in this area:**

The implementation of Care Support and Treatment has been very successful . With the exception of paediatric ART, most of the targets set under NACP III are on course, while some are exceeded (e.g. the number of ART Centres and adults alive and on ART).  Improved access to free ART and Care Support: There is rapid scale up of ART centres which are linked to a network of related care, support and training facilities (Community Care Center, Centres of Excellence). Over time, new activities have been added such as the introduction of the Link ART Center, which have decentralized treatment and decongested ART centres.  Focus on improving quality of services: A decentralized supporting and supervision system is operational. Data generated is analyzed for better programming and focused supervision of poor performing facilities. Systematic collaboration between ART centres, Community Care Center as well as PLHIV networks helped to reduce the loss of follow-up and missed cases. Improved links with ICTC and enhanced IEC campaigns have resulted in earlier detection.  Supply chain management: As a result of a well monitored system, there has been regular and uninterrupted supply of ARV drugs.  Some challenging interventions were rolled out: Second line treatment for adults and children picked up in 10 centres of excellence and paediatric second line ART in 7 Regional Paediatric Centres. ART guidelines for TB-HIV co-infected patients are now being implemented.

**What challenges remain in this area:**

Some of the challenges in Care, Support and Treatment are:  Not all PLHIVs registered at ART Centres  Drug adherence and rational prescription are critical in ART. Although the directives of the Supreme Court had some positive impact, adherence to rational treatment by private practitioners remains an issue.

**6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**

Yes

**IF YES, is there an operational definition for orphans and vulnerable children in the country?:**

Yes

**IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:**

Yes

**IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:**

Yes

**IF YES, what percentage of orphans and vulnerable children is being reached? :**

-

**7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

There is significant scale up of availability and access to ART by CLHIV. There are also many more programmes on the ground for care and support of Children Affected by AIDS (CABA) such as CHAHA: A home and community based programme of care and support funded by GFATM and implemented by Alliance India through a network of NGO.

**What challenges remain in this area:**

Remaining challenges are: 1) Identification, size estimation and provision of care and support in moderate and low prevalence settings. 2) Provision of institutional care and support remain.

## **A - VI. MONITORING AND EVALUATION**

**1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:**

Yes

**Briefly describe any challenges in development or implementation:**

Some of the key challenges in successful implementation of M&E system in India are: 1. Ensuring quality of data reported from over 14,000 reporting units across the country. 2. Adoption of standard definitions of monitoring indicators across all reporting units. 3. Enhancing use of data at state and district levels for decentralised programme planning and implementation. 4. Ensuring reporting from interventions implemented by partner agencies in uniform formats.

**1.1 IF YES, years covered:**

4 years. Since 2007

**1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:**

Yes, some partners

**Briefly describe what the issues are:**

Most key partners have aligned and harmonized their M&E systems to that of the government. Common definitions have been arrived at through intensive discussions and debates regarding the situations faced on the ground. However, some of the donors / partners are in the process of achieving harmonization through changes in their reporting systems due to host government requirements.

2. Does the national Monitoring and Evaluation plan include?

**A data collection strategy:**

Yes

**Behavioural surveys:**

Yes

**Evaluation / research studies:**

Yes

**HIV Drug resistance surveillance:**

Yes

**HIV surveillance:**

Yes

**Routine programme monitoring:**

Yes

**A data analysis strategy:**

Yes

**A data dissemination and use strategy:**

Yes

**A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):**

Yes

**Guidelines on tools for data collection:**

Yes

**3. Is there a budget for implementation of the M&E plan?:**

Yes

**3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :**

3.5%

**4. Is there a functional national M&E Unit?:**

Yes

**Briefly describe any obstacles:**

-

4.1. Where is the national M&E Unit based?

**In the Ministry of Health?:**

Yes

**In the National HIV Commission (or equivalent)?:**

Yes

**Elsewhere [write in]?:**

-

Permanent Staff [Add as many as needed]

**POSITION [write in position titles in spaces below] Fulltime Part time Since when?**

Deputy Director General (M&E)	Full Time	-	-
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Temporary Staff [Add as many as needed]

**POSITION [write in position titles in spaces below] Fulltime Part time Since when?**

National Programme Officer (Strategic Information)	Full Time	-	-
Programme Officer (M&E)	Full Time	-	-
Epidemiologist	Full Time	-	-
Programme Officer (Surveillance)	Full Time	-	-
Programme Officer (Biomedical and Clinical Research)	Full Time	-	-
Programme Officer (Evaluation and Operational Research)	Full Time	-	-
Monitoring & Evaluation Officer	Full Time	-	-
Monitoring & Evaluation Officer	Full Time	-	-
g & Evaluation Officer	Full Time	-	-

g & Evaluation Officer	Full Time	-	-
g & Evaluation Officer (BSD)	Full Time	-	-
g & Evaluation Officer (CST)	Full Time	-	-
Technical Officer (R&D)	Full Time	-	-
Technical Officer (Surveillance)	Full Time	-	-
Technical Assistant	Full Time	-	-

**4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:**

Yes

**Briefly describe the data-sharing mechanisms:**

All major implementation partners (including development partners) contributed their M&E data for compilation in the Dashboard for monitoring of programme performance. This dashboard of indicators is an agreed set of indicators between NACO & development partners for periodic reviewing of national AIDS response. The mechanism for ensuring submission of M&E data by major implementing partners is the Computerized Management Information System (CMIS) / Strategic Information Management System (launched in 2010 and being rolled out across county).

**What are the major challenges in this area:**

Process for stakeholders to report to the national M&E system through a set of uniform indicators is on-going. In some states the mechanisms are working better as compared to others. The main challenge is the difference in reporting formats across partners.

**5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:**

Yes

**6. Is there a central national database with HIV- related data?:**

Yes

**IF YES, briefly describe the national database and who manages it:**

The national database is the Computerised Management Information System (CMIS). The Strategic Information Management System (SIMS) - improving on the CMIS by addressing its issues with data reporting and data quality - was launched in August 2010. The roll out of SIMS is in progress in phased manner. By December 2011, SIMS is rolled out nation-wide and data entry is in progress in all states. CMIS and SIMS are managed by the M&E unit of NACO.

**6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:**

Yes, all of the above

**6.2. Is there a functional Health Information System?**

**At national level:**

Yes

**At subnational level:**

Yes

**IF YES, at what level(s)?:**

There are state and district level reporting units which collect and collate data from implementing units to pass on to the national level. A manual system collects data from each of the implementing units and passes on to the M&E units at the SACS. Here it is computerized and fed into the computerized management information system of NACO. However, when SIMS gets functional, all reporting units can directly enter monitoring data into web based system.

**7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:**

Yes

**8. How are M&E data used?**

**For programme improvement?:**

Yes

**In developing / revising the national HIV response?:**

Yes

**For resource allocation?:**

Yes

**Other [write in]:**

Research and Advocacy

**Briefly provide specific examples of how M&E data are used, and the main challenges, if any:**

Examples of M&E data used for developing / revising the national AIDS strategy are: • Firstly, the epidemiological profiling exercise of the HIV/AIDS scenario at district and sub-district level and the district re-categorisation exercise for prioritising interventions. This is one of the many examples of the evidence based planning that NACO has used. • Secondly, development of the migrant strategy and refocusing of care and treatment involves programme is based on data review. • The challenges include issues related to data quality, data validation, data analysis and relevance of data that is collected. Examples of M&E data used for resource allocation: • Human resource requirement at treatment, care and support centres is

determined according to data. If the client load is very high at an ICTC centre, for example, the number of counsellors is increased. It is used also for identifying data gaps and initiating operational research studies for programme improvement. Examples of M&E data used for programme improvements: □ Establishment of Technical Support Units and LAC is based on M&E data. □ TI funding is determined on its basis. □ Programme improvement through operational research and evaluation studies. Challenges are over data quality. Improvement and development of Knowledge hub.

9. In the last year, was training in M&E conducted

**At national level?:**

Yes

**IF YES, what was the number trained:**

Approx 37

**At subnational level?:**

Yes

**IF YES, what was the number trained:**

Approx 562

**At service delivery level including civil society?:**

Yes

**IF YES, how many?:**

Approx 9667

**9.1. Were other M&E capacity-building activities conducted` other than training?:**

Yes

**IF YES, describe what types of activities:**

The following was conducted: 1. Epidemiological profiling of districts based on the HIV/AIDS scenario and District re-categorisation exercise. 2. District AIDS Prevention Control Units training. 3. Training on SPSS and MIS 4. Programme management and HR management capacity development workshops conducted for project directors and programme staff. 5. Continuing Education Programme for State M&E Officer 6. Dissemination of 2010 estimates and orientation to the estimation process. 7. Two capacity building workshop in Ethics & HIV/AIDS in Pune and Chennai 8. Development of National Ethics Guidelines on HIV/AIDS related research. 9. Organisation of National Conference on HIV/AIDS Research in India on the theme "Towards Evidence-Policy linkages in HIV/AIDS Research" and continuing education programme for young professionals

**10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:**

9

**Since 2009, what have been key achievements in this area:**

Some of the key achievements are: (i) Generating new epidemiological information to inform NACP III and NACP IV planning such as via the district re-categorisation exercise for prioritising interventions (ii) Strengthening Programme Monitoring: a. Health information management system strengthening and ensuring smooth transitioning from the Computerised Management Information System (CMIS) to the Strategic Information Management System (SIMS) which was launched in August 2010 and is being rolled out. b. Monitoring data from reporting units — with specific focus on dashboard indicators — to assess programme implementation progress and identify opportunities for course correction. c. Generation of high quality periodic reports and technical documents and facilitating its availability. d. Strengthening capacities for validating and analysing programme data. (iii) Strengthening strategic information on the epidemic: a. Strengthening mechanisms to improve quality of HIV Sentinel Surveillance data b. Generating HIV Estimates using the latest globally recommended methodologies and tools (iv) Strategic planning for the Annual Action Plan based on programme data. (v) Development of State Fact Sheets that provide an overview of service delivery in each state under different programme components.

**What challenges remain in this area:**

-

## **B - I. CIVIL SOCIETY INVOLVEMENT**

**1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:**

3

**Comments and examples:**

Civil society in India has actively engaged itself in AIDS response. Most notable initiatives by them included the following: Firstly, contribution to the planning process of the National AIDS Control Programme. For NACP IV planning, interface was facilitated by NACO for civil society to have their voices heard such as via participation in working group discussions, through regional consultations, meetings with the Planning Commission etc. Civil society engagement is not merely related to voices being heard but also about guiding the national programme through representation in TRG meetings, consultations for developing strategies, modules, guidelines etc. Secondly, civil society actively contributed to programme implementation particularly the Targeted Intervention projects for HIV prevention. Towards an enabling environment, civil society, thirdly, actively campaigned for the eradication of discriminatory laws that acted as barriers to HIV prevention, treatment, care and support — such as Section 377 of the Indian Penal Code. They recommend revision of the Immoral Traffic Prevention Act (ITPA) 1956, and Narcotics Drugs and Psychotropic Substances (NDSP) Act 1985, Section 299 of the Indian Penal Code that prohibits production/distribution of materials that could be obscene. Position papers, briefings etc. were developed by them for the same. The most noted contribution of civil society - particularly through representation from the MSM community - was their

effective campaigning which resulted in the reading down of Section 377 of the Indian Penal Code . It was also a liberal and informed judgment that was made by the High Court of Delhi. Another outcome of the advocacy efforts of the civil society has been the stalling of the proposed amendment of the ITPA Amendment Bill. The proposed amendment, if approved, would result in setting up of barriers for sex workers to access HIV services. Fourthly, PLHV have been engaged in strong advocacy for scaling up of the ART programme and introduction of second line ART. Civil society also campaigned in favor of ensuring supply of generic drugs, including ART, for HIV treatment. The civil society recognize that AIDS response in India receives patronage from the political leadership at the highest level starting from India Prime Minister who chairs the National Council on AIDS. Civil society would, however, like stronger two way dialogue between the political leadership and civil society which often is restricted to few sporadic platforms. The political leadership in some specific states such as the southern Indian states has shown strong commitment to AIDS response. This though is not consistent across all states. Civil society would like to contribute more strongly to NACP implementation and also to budgeting. They see scope for increasing civil society involvement in making GIPA operational. Scores awarded by civil society on the level of contribution has remained consistent under the 2012 and 2010 rounds.

**2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:**

3

**Comments and examples:**

Civil Society representatives were part of the planning process for the National AIDS Control Program (NACP) phase IV. The civil society caucus was formed to bring together voices of civil society which fed into this process at various levels through broader consultation with constituency groups. Civil society was part of the sub groups for NACP IV planning in 2011. Over 25 consultations were held among the Civil Society across the country and detailed reports were presented to NACO and Planning Commission. Civil society waits to receive feedback on the same. All NACP IV strategy discussion were uploaded on the NACO website. However, since the current proposal is with the Planning Commission, NACO cannot share the current status. Civil society was engaged in discussions on budgeting during the NACP IV working group meetings (such as working group on men having sex with men [MSM]) that few civil society representatives participated in. Civil society however would have like greater involvement in NACP IV budgeting. Under the NACP phase III, civil society contribution was centered on programme implementation vis-à-vis planning. Participation in State Annual Action Plan designing could be increased as civil society is keen to be more actively involved in planning and budgeting with Government. This is incorrect. The modification were made following discussion in Technical Resource Group (TRG) meetings. In the TRGs community and civil society groups are adequately represented . Civil society at national and state level sees scope for their engagement in this field. The score for this section is increased by 1 mark from the 2010 round to 2012 round. Civil society representative were members of the working group on HIV/AIDS for 12th plan and steering committee constituted for the planning on health commission

3.

**a. The national HIV strategy?:**

3

**b. The national HIV budget?:**

2

**c. The national HIV reports?:**

1

**Comments and examples:**

The National AIDS Strategy includes civil society as partners for implementing several services for HIV prevention and care and support. This is built in to the programme design and budget. Services are provided by civil society for HIV prevention, treatment, care and support albeit in varying degrees and at varying levels. Specifically, all preventive interventions for female sex workers, men who have sex with men, injecting drug users through Targeted Interventions are implemented by civil society. HIV Treatment services are mostly delivered by the Government Ministries though follow up of people living with HIV is supported by civil society. In the area of Care and Support, a few civil society organizations and networks have played a role at the community level and institutional level to help create an environment more enabling for AIDS response. Civil society has played a central role in supporting behavior change, persuading communities to protect themselves, reduce risk and even inspiring the general population to be more inclusive, break the silence on HIV and respond to the epidemic without a sense that it is a taboo subject matter. The level of civil society contribution may not be acknowledged adequately in some instances. A meaningful partnership is yet to evolve between civil society and the government so that the former is considered an asset.

4.

**a. Developing the national M&E plan?:**

1

**b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?**

:

2

**c. Participate in using data for decision-making?:**

1

**Comments and examples:**

Civil society and community representatives have been part of TI evaluations conducted in the states. The M & E generated from the field through NACO MIS is provided by the community themselves. There was an identified need for stronger collaboration between civil society and the M&E division at national and state levels on (i) key findings and trends emerging from programme monitoring data, the evaluation studies and (ii) implications of programme data on on-going

and planned interventions. Easier access to data (disaggregated by sex, age and population group) and data use was envisaged as a means for them to understand the level of progress made. It was recommended that stronger focus be placed on having scientific articles and M&E data analysis made available.

**5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:**

4

**Comments and examples:**

Civil society play an important role in implementing Targeted Interventions for HIV prevention and providing care and support to people living with HIV and key population through Drop in Centre interventions. Civil society also is engaged in advocacy initiatives at the national level and grass root level. For example civil society at the grass root level has engaged political leaders by inviting them to their rallies on HIV/AIDS. Local leaders, district level members of Legislative Assemblies are also invited to such events. Contributions made by civil society are not uniform on a pan India basis as the level of engagement is often determined by the individual organizations' capacities. These capacities need to be strengthened and overall civil society contribution across India expanded. There was a recognized need for developing closer coordination and networking amongst the civil society — which consists of Non-governmental Organizations; Community Based Organizations; Civil Society Organizations', Networks of PLHIV, sexual minorities, men who have sex with men, Transgender, female sex workers, injecting drug users etc. — so that they may play a stronger role in AIDS programming and implementation.

6. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access

**a. Adequate financial support to implement its HIV activities?:**

2

**b. Adequate technical support to implement its HIV activities?:**

2

**Comments and examples:**

Civil society receives both financial and technical support for project implementation or specific activities from the Government and is dependent on them. Opportunities for accessing funds outside the public domain was considered limited by civil society representatives. Moreover, as most organizations or networks are with limited technical capacities they are reliant on the expertise they receive from the Government along with other opportunities for mentoring and supportive supervision. The level of financial support was not optimal for implementing HIV preventive interventions particularly considering the practical challenges of implementing interventions in remote or rural settings or when the spread of target population was dispersed all over the region which increases travel costs for instance. There is no or limited scope of flexibility offered for the budgets to address these situations. The level and quality of technical support received has improved through the National Technical Support Unit and state Technical Support Units. There is technical staff at Targeted Interventions, Drop in Centers and Community Care Centers though variance exists across states. The turnover of technical staff is very high. There is a felt need for stronger technical support to improve quality of interventions. The score remain consistent with 2010.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

**People living with HIV:**

>75%

**Men who have sex with men:**

>75%

**People who inject drugs:**

>75%

**Sex workers:**

>75%

**Transgendered people:**

>75%

**Testing and Counselling:**

<25%

**Reduction of Stigma and Discrimination:**

>75%

**Clinical services (ART/OI)\*:**

<25%

**Home-based care:**

>75%

**Programmes for OVC\*\*:**

>75%

**8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

There has been a continuous increase in civil society involvement in NACP III implementation particularly in implementation of Targeted Intervention projects for HIV prevention; and, provision of care and support for the key populations of PLHIV, men who

have sex with men, injecting drug users and female sex workers. The efforts of civil society are noted in home care and support. Civil society representatives are included in District AIDS Prevention Control Units (DAPCUs) and involved in district level programming and implementation. They were resource persons in various workshops and helped sensitize people on the needs of PLHIV and key population groups. They also participated in national consultations and other discussion forums to advocate for introduction of special impact alleviation schemes for people living below the poverty line, for widows, and travel concessions for accessing ART etc. Civil society campaigned for free CD4-testing and free testing for opportunistic infections. One of civil society's key achievements — and which resulted from their sustained advocacy efforts — was the recognition of Transgender as a group separate from men having sex with men for targeted interventions. Also, following civil society's strong encouragement for formation of new Community Based Organisations, these are being formed to support Targeted Interventions. Civil society representatives were engaged in NACP IV planning and provided their contribution to working group meetings and meeting with the Planning Commission.

**What challenges remain in this area:**

Civil society would like a true partnership forged between the Government and themselves in AIDS response. Civil society would like improved coordination at the state and national levels and a greater involvement of PLHIV and all Higher Risk Groups in all components of the programme. Their current engagement is programme Monitoring and Evaluation and activity budgeting is negligible and it was recommended that this be addressed.

## B - II. POLITICAL SUPPORT AND LEADERSHIP

**1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:**

Yes

**IF YES, describe some examples of when and how this has happened:**

Civil society was involved in HIV policy design and implementation. They contributed actively to NACP IV planning process at the national level. As members of NACO working groups, they participated in the series of meetings held during quarters two and three of 2011. Additionally, at regional and state levels, opportunity was created for them to hold consultations and discussions on programme components. The recommendations emerging through these consultations were consolidated and presented to NACO and the Planning Commission. Civil society representatives are also members of State AIDS Councils and Technical Resource Groups/Committees at national and state levels and have contributed to the programme. Following identification of Transgender as a separate core Higher Risk Group and independent of men having sex with men, civil society contributed to development of Transgender guidelines. They supported the call for amendment of Section 377 of the Indian Penal Code with NACO. Whilst recognizing these initiatives, civil society urge for their greater engagement and participation in policy making and programming.

## B - III. HUMAN RIGHTS

1.1.

**People living with HIV:**

No

**Men who have sex with men:**

No

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs:**

No

**Prison inmates:**

No

**Sex workers:**

No

**Transgendered people:**

No

**Women and girls:**

No

**Young women/young men:**

No

**Other specific vulnerable subpopulations [write in]:**

-

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**

Yes

**If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:**

The Constitution of India guaranteed Fundamental Rights to all citizens under its following Articles:  Article 14: Equality

before law  Article 15: Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth  Article 16: Equality of opportunity in matters of public employment  Article 21: Protection of life and personal liberty  Article 21A: Right to Education There are specific legislations for women such as: • The Domestic Violence Act 2005 for the protection of rights of women who are victims of violence occurring within the family and incidental matters. • The Dowry Prohibition Act (Sections 498A, 304B of the Indian Penal Code) prohibits the demand, provision and receipt of dowry in specific circumstances. • The Hindu Succession (Amendment) Act, 2005, remove the gender discriminatory provisions and has granted equal rights to a woman (of Hindu faith) in the self-acquired and coparcenary property of her father. • In addition provisions of the Indian Penal Code related to rape (Sections 375, 376) further provide protection to women. Specific legislations for children include: • The Juvenile Justice Act 2000 which provides for children in need of care and protection. • The Right to Education 2010 provides free and compulsory education to every child in the age group 6- 14 years and makes specific mention of children with disabilities and children from weaker and disadvantaged communities. As none of the laws relating to women and children had satisfactory anti-discrimination clauses, according to civil society representatives, the answer to question 1 of this section is marked as 'NO.' In addition to legislations, there are safety net programs and entitlements for women and vulnerable populations such as Widow pension, Old age pension, bus pass concessions, and the Employment Guarantee Act. State specific protective policies were introduced for Transgender through Government Orders in Tamil Nadu (2009) and Karnataka. It was recommended that anti-discriminatory laws specific to PLHIVs and Higher Risk Groups be introduced.

**Briefly explain what mechanisms are in place to ensure that these laws are implemented:**

Following mechanisms are in place: • The Indian Constitution provides a citizen the right to move the Supreme Court when a fundamental right is infringed (Article 32 (1) of the Constitution of India). • The Indian Constitution empowers the High Court and Supreme Court to issue directions, orders or writs against violations of Constitutional rights (Article 32 (2) of the Constitution of India). • Rights bodies including the National and State Human Rights Commissions; National and State Commission for the Protection of Child Rights; Press Council of India; National and State Commission for Women monitor violations of the rights and direct appropriate remedy. • National, State and District Legal Services Authorities provide access to free legal aid for weaker sections of society. • Right to Information Act 2005 provides citizens the right of information and provides mechanisms to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority.

**Briefly comment on the degree to which they are currently implemented:**

Policies exist but there is need for stronger focus on enforcement. Currently, Section 377 of Indian Penal Code — which criminalizes non-peno-vaginal penetrative sex even between consensual adults and hence discriminatory to men having sex with men and Transgender — is fought in the light of constitutional inclusiveness and anti-discrimination. Delhi High Court in its 2009 order has decriminalized all kinds of consensual sexual acts between consenting adults in private. The Supreme Court is presently hearing appeals against this high court order.

**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**

Yes

2.1. IF YES, for which sub-populations?

**People living with HIV:**

No

**Men who have sex with men:**

Yes

**Migrants/mobile populations:**

No

**Orphans and other vulnerable children:**

No

**People with disabilities:**

No

**People who inject drugs:**

Yes

**Prison inmates:**

Yes

**Sex workers:**

Yes

**Transgendered people:**

Yes

**Women and girls:**

No

**Young women/young men:**

Yes

**Other specific vulnerable subpopulations [write in]:**

-

**Briefly describe the content of these laws, regulations or policies:**

Provisions of the following Acts continue to be obstacles for reaching most at risk populations and in some cases result in violence and harassment • Men having sex with men: Section 377 of the Indian Penal Code considers unnatural or carnal intercourse against the order of nature which includes non – penile vaginal sex between man and woman, man and man and man with animal and criminalizes the same with punishment of up to 10 years. The reading down of Section 377 by Delhi High Court in July 2009 decriminalized consensual sex between adults encouraging the men having sex with men (MSM)

community to come out in the open. The judgement has contributed to creating an enabling environment for CSO to reach out to MSM community with HIV prevention and treatment services. This Judgement however is currently being challenged in the Supreme Court of India.

- **Injecting drug users-** The Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 lays out a framework for drug control and proscribes production, cultivation, manufacture, sale, possession and consumption of cannabis, opium, cocaine and other psychotropic substances as illegal. The NDPS is strongly enforced. People who use drugs tend to be arrested for consumption and/or possession of drugs even if in small quantities. Both are punishable offences with a jail term of 6 months to 1 year depending on the drug. Although the Act allows persons dependent on drugs to receive treatment, in practice the provisions are cumbersome and unrealistic. Moreover treatment is understood narrowly to mean “drug free” ruling out evidence based and effective method of maintenance, and buprenorphine substitution for opioid dependence. The Act pays scant attention to the risk of HIV and other blood borne infections. On the contrary, it threatens harm reduction programmes of needle syringe provision with prosecution for “abetment”.
- **Sex Workers:** The Immoral Traffic (Prevention) Act 1956 or ITPA regulates sex work while penalizing trafficking or procurement and detention in organised sex work. The Act bestows the police with special powers for arresting sex workers and raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. These raids, however, drive sex workers underground. This inhibits their access to health care and or preventive interventions.
- **Transgender / Eunuchs:** Andhra Pradesh (Telengana Area) Eunuchs Act, 1329 is an enactment for the ‘registration and control of eunuchs’. Section 2 of the Act provides for the maintenance of a register by the government that will contain the names and place of residence of all eunuchs residing in Hyderabad or at any other place and ‘who are reasonably suspected of kidnapping or emasculating boys or of committing unnatural offences or abetting commission of those offences’.
- Section 320 Indian Penal Code, penalises emasculation as causing Grievous Harm to an individual.
- Section 159, 160 of the Indian Penal Code is intended to punish individuals who are disturbing public peace by fighting in a public space.
- Some States have Government Policies which prevent dissemination of IEC material on Life Skill Education since they are held to ‘violate child pornography related laws.’
- Prison manuals require compulsory HIV testing of prisoners on entry. In some states, prisons segregate prisoners’ living with HIV/AIDS.

**Briefly comment on how they pose barriers:**

These Acts pose as barriers in the following way:

- Section 377 of the Indian Penal Code criminalizes adult consensual sex. It violates the fundamental rights of sexual minorities and creates obstacles for reaching out and providing services to MSM '22' community. Reading down Section 377 in July 2009 de-criminalised consensual sex between adults. The judgment has helped to create an enabling environment for CSOs to reach out to the MSM community with HIV prevention and treatment services. The judgment is currently being challenged in the Supreme Court of India. In some states confusion prevails on the application of the judgement.
- Under the NDPS Act, 1985, people who use drugs can be arrested for consumption/or possession of drugs even in small quantities. Though the Act allows persons dependent on drugs to receive treatment, ‘treatment’ itself is understood only in the context of complete rehabilitation from drugs or being drug free. Alternate methods of maintenance, buprenorphine substitution for opioid dependence are not recognised. Risk of HIV and other blood borne infections are ignored. The Act in its application, threatens the needle syringe provision of harm reduction programs, with prosecution for abetment. Some NGOs have petitioned against these provisions and the cases are being heard by the High Courts.
- Sections of ITPA empower police officers to arrest sex workers, raid brothels for rescuing individuals forced into sex work or human trafficking. There is no differentiation between women forced into prostitution through trafficking and women who are voluntarily in sex work. Consent of women voluntarily in sex work is not sought and they are forced into rehabilitation homes. The clauses are used to harass women in sex work arrest them under false pretexts. These raids drive sex workers underground and inhibit their access to health care and preventive interventions.
- While there are no recorded cases of the Andhra Pradesh (Telengana Area) Eunuchs Act, 1329 being applied; the provisions violate the fundamental rights of transgender people.
- The Indian Penal Code provisions criminalising emasculation adversely impact transgender people seeking to undergo SRS procedures.
- The Indian Penal Code provisions on disturbing public peace are often used by law enforcement to detain and arrest female sex workers, MSM, Transgender people in public spaces. This impacts outreach and prevention efforts since the sex workers, MSM and TG and driven underground.
- Forcible testing and segregation of prisoners on ground of their status violates their basic human rights and exposes them to stigma and discrimination

**3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:**

Yes

**Briefly describe the content of the policy, law or regulation and the populations included:**

The country has the following laws or regulations to reduce violence against women:

- Domestic Violence Act 2005 provides for the protection of rights of women who are victims of violence occurring within the family and incidental matters.
- The Dowry Prohibition Act prohibits demand, giving and receiving of dowry in specific circumstances. This protects women from dowry demands within marriage.
- Sexual Harassment at workplace guidelines by the Supreme Court in 1997 lays down guidelines for protecting women from sexual harassment in the workplace. Consequently, the Protection of Women against Sexual Harassment at Workplace Bill 2010 was tabled in the Parliament in 2010. The proposed bill seeks to enact a comprehensive legislation to provide safe, secure and enabling environment for women in her workspace.
- The Indian Penal Code has various sections that protect women and punish acts of violence including rape (Section 375, 376), cruelty by husband or relatives (Section 498-A), procuring minor girls for prostitution (Section 366-A), kidnapping a woman to compel her marriage (Section 366), causing a miscarriage without a woman’s consent (Section 312).
- Medical Termination of Pregnancy Act, 1971 legalises termination of pregnancy on various socio- medical grounds and is aimed at eliminating abortion by untrained persons in un-hygienic conditions.
- The Pre - Conception and Pre -Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 seeks to prohibit pre - natal diagnostic techniques for the determination of the sex of the foetus and prevent female foeticide. Challenges Despite the protection available to women under these Laws, access and timely redress continue to be a challenge. This is more pronounced for vulnerable and marginalised women such as sex workers and women living with HIV/AIDS. Further, the specific vulnerabilities of women in sex work and women living with HIV/AIDS are not effectively addressed in the laws or regulations. Women are discouraged from accessing courts of law to seek redress for the violence they may have experienced or else are deterred because of (i) delays in justice and (ii) the often insensitive

procedures met out to them. Article 16, CEDAW is yet to be ratified. The practice of child marriage or early marriage is prevalent in parts of India and there have been instances of forced marriage. Progressive legislations such as Domestic Violence Act are limited in their application for women experiencing violence in the domestic setting.

**4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:**

Yes

**IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:**

Human rights protection is mentioned in the following HIV policies / strategies: • The Strategy and Implementation Plan for NACP III • The GIPA policy • The policy on gender mainstreaming • Protection of Children in the Ministry of Women and Child Development scheme • Additionally, states such as Nagaland and Manipur have specific HIV policies The existing policies however need to be implemented in a sustained manner as there are cases of human rights violation. Certain practices carried out under the programme such as classification of 'high volume' / 'low volume' sex workers and the enumeration process were regarded by civil society as violation of the privacy of sex workers. Civil society highlighted that the current classification of injecting drug users as regular and non regular injectors limited the latter's access to essential harm reduction services. CSO noted their concern that information collected for line listing most at risk populations (MARPS / HRGs) by NACO may result in discrimination in the absence of a strong mechanism to ensure consent and confidentiality.

**5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:**

Yes

**IF YES, briefly describe this mechanism:**

There are certain mechanisms in place for addressing stigma and discrimination. For instance, crisis management systems do exist under Targeted Interventions for female sex workers, men having sex with men, Transgender, injecting drug users. Crisis response strategies have also been developed in some states and across some prevention projects. In the state of Tamil Nadu, cases are recorded by CSO. These are subsequently forwarded to the SACS and then to NACO. Sero-positive people may report grievances at any police station. There is a designated police officer in each state. There is a process in place but mechanisms to implement them need strengthening. The media has played a part in highlighting cases of discrimination against people living with HIV and AIDS. This though needs to be strengthened with greater focus on documentation of Stigma and Discrimination against PLHIV and increased media coverage on these issues.

**6. Does the country have a policy or strategy of free services for the following?**

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Yes	-	-
-	Yes	-
-	Yes	-

**If applicable, which populations have been identified as priority, and for which services?:**

According to the Strategy and Implementation Plan for NACP III and Policy: • Women living with HIV and children identified with HIV are prioritized for ART treatment. • Core higher risk groups of female sex workers, men having sex with men, transgender, and injecting drug users followed by bridge population groups of migrants and truckers are prioritized for HIV prevention interventions Civil society recommended that the package of services made available for HIV prevention include: • Free Female condoms for female sex workers. • Greater focus awarded to partners and spouses of higher risk groups to prevent further HIV proliferation.

**7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:**

No

**7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:**

No

**8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:**

Yes

**IF YES, Briefly describe the content of this policy/strategy and the populations included:**

The National AIDS Control Prevention Policy 2002 articulates equal access for most at risk and vulnerable populations to prevention, treatment, care and support services. Different prevention approaches are articulated for female sex workers, men having sex with men and injecting drug users and a minimum package of services for each.

**8.1**

**8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:**

Yes

**IF YES, briefly explain the different types of approaches to ensure equal access for different populations:**

The policy does articulate different approaches for female sex workers, men having sex with men and injecting drug users and provides them with a minimum package of services. Civil society however expressed the need for the programme to include different and additional approaches for reaching out to sub groups within the key population such as for different categories of female sex workers, men having sex with men and injecting drug users. Certain level of flexibility in implementing interventions at the grass root level would help enable this. Need was felt for stronger focus on partners of

female sex workers, men having sex with men, Transgender and injecting drug users; and prison inmates.

**9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:**

Yes

**IF YES, briefly describe the content of the policy or law:**

The HIV testing and counselling policy prohibits pre-employment HIV screening. The policy is articulated in the National Guidelines for Integrated Counseling and Testing Centres and in the National AIDS Policy of 2002. This was accepted by the Ministry of Labour in October 2009. Although The HIV Bill is yet to be ratified by Parliament; it does include detailed provision for prohibiting discrimination in the workplace in matters of recruitment, re-assignment, promotion and termination.

**10. Does the country have the following human rights monitoring and enforcement mechanisms?**

**a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:**

Yes

**b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:**

No

**IF YES on any of the above questions, describe some examples:**

India has several institutions for promoting and protecting human rights such as the National Human Rights Commission; State Human Rights commissions; Law Commission of India; National Legal Services Authorities; State Legal Services Authorities; District Legal Services Authorities; National Commission for the Protection of Child Rights; State Commission for the Protection of Child Rights; National Commission for Women and State Commission for Women. These institutions promoted and protected against Human Rights violations. For instance, the National Legal Services Authorities; State Legal Services Authorities; District Legal Services Authorities undertook initiatives to protect rights of Transgender and people living with HIV with notable instances in 2011. The State Commissions for the Protection of Child Rights in Karnataka, Tamil Nadu, Maharashtra, and Manipur held public hearings in 2011 to uphold and protect rights of children living with HIV/AIDS. However on the whole, monitoring of human rights violations by the Commissions and institutions is in a nascent stage. Greater promptness in action is required for ensuring timely and effective protection of Human Rights. The Press Council on India continued to uphold the rights of communities and against sensational reporting.

**11. In the last 2 years, have there been the following training and/or capacity-building activities**

**a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:**

Yes

**b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:**

Yes

**12. Are the following legal support services available in the country?**

**a. Legal aid systems for HIV casework:**

Yes

**b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:**

No

**13. Are there programmes in place to reduce HIV-related stigma and discrimination?:**

Yes

**IF YES, what types of programmes?**

**Programmes for health care workers:**

Yes

**Programmes for the media:**

Yes

**Programmes in the work place:**

Yes

**Other [write in]:**

-

**14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

The key achievements since 2009 have been the following: • The Supreme Court of India upheld the principle of Universal Access to second line ART in December 2010. • Section 377 of the Indian Penal Code was read down in July 2009 and adult

consenting homosexual relations was decriminalized by the Delhi High court. • In 2010 the Delhi High Court ordered all government hospitals to provide one dialysis machine for HIV positive people. • Recognition of Transgender as segment of Backward Communities which made them eligible for safety net schemes in Karnataka, 2010/2011. • Grant of compulsory license patent for cancer medication by the patent controller in March 2012 was a landmark judgment for the rights of communities affected by various health concerns to affordable medicines. • Successful opposition to patents on life saving drugs such as Tenofovir (TDF) and Valganciclovir.

**What challenges remain in this area:**

Challenges remaining in this area include: • The Narcotic Drugs and Psychotropic Substances Act and Immoral Traffic (Prevention) Act are barriers to HIV prevention, treatment, care and support services. • Application of Delhi High Court judgment on Section 377 of the Indian Penal Code remains confused. • A comprehensive Hepatitis C Policy for addressing vulnerabilities of injecting drug users to HIV- Hepatitis C infection — and access to appropriate treatment services — is required. • Laws relating to prisoners and HIV need to be addressed. • The HIV Bill is yet to be tabled in Parliament and passed as a law to ensure comprehensive anti-discrimination legislation and protection to vulnerable populations.

**15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:**

2

**Since 2009, what have been key achievements in this area:**

Since 2009, key achievements have been the following: • The National Legal Services Authorities in 2011 recognized and emphasized on the equal rights of transgender people and their need for legal remedy to fight discrimination. • State Legal Services Authority in Andhra Pradesh and, Karnataka actively reached out to transgender people in 2011 and encouraged them to access courts in case of rights violations.

**What challenges remain in this area:**

The country needs to work more towards: • Effective implementation of existing laws and policies. • Enabling PLHIV, female sex workers, transgender people, men having sex with men and injecting drug users’ easier access to legal systems with focus on delivering speedy justice. • Greater sensitivity to the requirements and concerns of PLHIV, female sex workers, transgender people, men having sex with men and injecting drug users’ by law enforcement agencies.

## **B - IV. PREVENTION**

### **1. Has the country identified the specific needs for HIV prevention programmes?:**

Yes

**IF YES, how were these specific needs determined?:**

The specific needs for HIV prevention programmes is determined through: • Inputs from the ongoing Targeted Interventions for HIV prevention among female sex workers, men having sex with men and injecting drug users are provided at the state level through the State AIDS Control Societies (SACS) responsible for implementing the NACP III. • Mapping of higher risk groups / most at risk populations, and other strategic information and evidence generated through operations research. • Feedback from targeted population on their needs and issues. Example, the community was involved in planning the Harm reduction programme. • Pilot projects, which are later scaled up as interventions across the country is another way of identifying and addressing needs. For example, integration of AYUSH with ASHA for strengthening health care delivery etc. The link workers scheme was also introduced through assessment of grass root level requirements. • For addressing the service needs of the rural HRG and vulnerable population. STI/RTI preventive services for the FSW, MSM, Transgender, IDU Migrants and truckers were provided through an innovative approach by their own providers at their door steps (Preferred providers). All the HRG were provided with free STI/RTI treatment and serological testing for syphilis to reduce reproductive morbidity and HIV infection amongst them. Moreover STI/RTI preventive services were universally offered to all population through health care delivery system. Challenges The methodologies of various interventions were developed at the national level. The SACS also has a role in this and in many states grass roots requirements are addressed in the annual action plans submitted to NACO. Civil society reiterated the need for stronger linkages between the HIV prevention and HIV treatment, care and support services to be established. A stronger referral system was required particularly for treating HIV co-infections so that the overall efficacy of interventions is increased. The service package offered under the HIV prevention programme could be expanded with greater focus on: • Addressing vulnerabilities of partners and spouses of female sex workers, men having sex with men and injecting drug users. • Focus on ensuring the well being of PLHIV through provision of adequate care and support. • Preventive interventions need to consider the vulnerability and needs of women including female injecting drug users. Stronger programme linkages with Reproductive Child Health programme were recommended. Additionally, although studies were conducted to highlight women’s vulnerability to HIV, the evidence is limited and more specific studies or pilots could be undertaken. • Greater focus on HIV prevention, treatment and care services for orphaned and vulnerable children. • Injecting drug users could be involved in a more meaningful manner in the Harm reduction programme at all levels to increase community ownership. Same for other higher risk populations who could be more closely involved in programmes for their respective groups • Treating HIV-Hepatitis C co-infection among PLHIV. • The link worker component was effective in reaching out to targeted populations but their interventions could be expanded further in rural areas. Stronger ownership by SACS of the Link Workers scheme was recommended by civil society. • Addressing stigma and discriminatory behavior experienced at the family level, community level, and in public health setting such as health through sensitization workshops, Information-Education-Communication etc. was recommended.

1.1 To what extent has HIV prevention been implemented?

**Blood safety:**

Agree

**Condom promotion:**

Agree

**Harm reduction for people who inject drugs:**

Agree

**HIV prevention for out-of-school young people:**

Strongly Disagree

**HIV prevention in the workplace:**

Strongly Disagree

**HIV testing and counseling:**

Agree

**IEC on risk reduction:**

Disagree

**IEC on stigma and discrimination reduction:**

Agree

**Prevention of mother-to-child transmission of HIV:**

Agree

**Prevention for people living with HIV:**

Disagree

**Reproductive health services including sexually transmitted infections prevention and treatment:**

Agree

**Risk reduction for intimate partners of key populations:**

Strongly Disagree

**Risk reduction for men who have sex with men:**

Agree

**Risk reduction for sex workers:**

Agree

**School-based HIV education for young people:**

Strongly Disagree

**Universal precautions in health care settings:**

Agree

**Other [write in]:**

Grievance redress, female condom, Information-Education-Communication related to PPTCT: Strongly Disagree.

**2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

The key achievements have included the following: • Scaling up and increased coverage of the HIV prevention programme. - Targeted interventions for higher risk groups and the bridge populations of migrants and truckers were scaled up. - The number of integrated counseling and tested centers (ICTC) has increased which has resulted in easier access. - The prevention of parent to child transmission programme (PPTCT) is being scaled up. • Infrastructure utilisation for programme implementation has improved. • There is greater community ownership and commitment of political leadership to address specific needs of people. There is an increased awareness and understanding of the NACP III at various levels. • Civil society was increasingly involved in program planning. For instance, the core population was involved in designing the strategies to implement HIV prevention programs for Transgender population. Community members were also involved in the planning process of interventions for Injecting Drug Users.

**What challenges remain in this area:**

Civil society highlighted the need for improved quality of services delivered under the prevention programme. They also recommend that the focus of the prevention programme and the services provided therein needs to focus more strongly on partners and spouses of higher risk groups. Additionally, include female injecting drug users and prisoners. Stigma and discrimination continued to act as barriers to service access and steps needed to taken to help create a more conducive environment for service uptake. As voluntary testing was not always adhered to at the grass root level, civil society representatives reiterated the need for stronger implementation of this Government policy.

**B - V. TREATMENT, CARE AND SUPPORT****1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:**

Yes

**IF YES, Briefly identify the elements and what has been prioritized:**

The package of treatment, care and support services was identified through baseline surveys, operations research and the data collected through interactions at the ART centres. The specific needs for HIV treatment, care and support were determined through engagement with civil society (though not at optimal levels). ART and Prevention of Parent to child Transmission Treatment norms were identified based on WHO guidelines. The service elements prioritized include: HIV testing, treatment for opportunistic infections, cross referrals, delivery of ART and Prevention of Parent to child Transmission services. Care and support services in line with HIV treatment are available and were scaled up recently. These though could be expanded further with care and support focused on addressing the various needs of PLHIV related to their nutritional support, counseling, livelihood options etc. CHALLENGES The use of a national framework for scaling up HIV treatment, care

and support services did not always take into account local requirements. Civil society highlighted the need for: • HIV - Hepatitis C co-infection investigation and treatment. • Increased access to alternative first line and second line regimens required. • Effective treatment for prevention of mother to child transmission of HIV. • Nutritional support for PLHIVs. Service uptake could be increased through improvement in quality of services and improved linkages with other departments. Early diagnosis was crucial for timely initiation of ART. Legislations that acted as legal barriers to people's access to services needed to be addressed. Successful donor supported pilots should be integrated into the national programmes such as was done for integrating Targeted Intervention projects of Avahan.

**Briefly identify how HIV treatment, care and support services are being scaled-up?:**

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**  
Agree

**ART for TB patients:**  
Agree

**Cotrimoxazole prophylaxis in people living with HIV:**  
Agree

**Early infant diagnosis:**  
Agree

**HIV care and support in the workplace (including alternative working arrangements):**  
Disagree

**HIV testing and counselling for people with TB:**  
Agree

**HIV treatment services in the workplace or treatment referral systems through the workplace:**  
Strongly Disagree

**Nutritional care:**  
Agree

**Paediatric AIDS treatment:**  
Agree

**Post-delivery ART provision to women:**  
Agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**  
Strongly Disagree

**Post-exposure prophylaxis for occupational exposures to HIV:**  
Agree

**Psychosocial support for people living with HIV and their families:**  
Agree

**Sexually transmitted infection management:**  
Agree

**TB infection control in HIV treatment and care facilities:**  
Disagree

**TB preventive therapy for people living with HIV:**  
Strongly Disagree

**TB screening for people living with HIV:**  
Agree

**Treatment of common HIV-related infections:**  
Agree

**Other [write in]:**  
Second line ART; Viral load testing: Agree Hepatitis C Test; Drug resistance test, compliance to treatment (Tx adherence): Strongly Disagree

**1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

• Opening of more ART Centre beyond the target set for NACP III • Treatment drugs for two months given at a time • ART plus centres to provide second line treatment closer to the residence • Rising CD4 level to 350 for initiation of ART. This has also reduced opportunistic infections among PLHIV. • Provision of free second line to the eligible PLHIV even if they have received earlier treatment from private sector

**What challenges remain in this area:**

-

**2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**

No

**3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:**

1

**Since 2009, what have been key achievements in this area:**

Following are the key achievements since 2009: • There are 7 Regional Pediatric Centers and which are being upgraded to Centers of Excellence for care and support to infected children. • A draft policy framework for Orphaned and Vulnerable children has been developed but is yet to be endorsed. • There is a plan in place for children infected or affected by HIV being implemented in selected districts in high prevalence states by the India HIV/AIDS Alliance which is a Principal Recipient of the GFATM Round 6 grant for the country. • A few pilot projects focused on meeting the HIV related needs of orphans and vulnerable children are ongoing

**What challenges remain in this area:**

Challenges in this area include: • Absence of a comprehensive programme design and budget allocation for delivery of effective treatment of children and infants living with HIV. • Stronger mainstreaming of HIV and AIDS services for Children Living with HIV within the existing health care system. • Stronger coordination between Government Ministries. • Laws and regulations for protecting children from sexual abuse. • Care and support for children living with HIV or affected with HIV; particularly street children and marginalized children. Nutritional support for children living with HIV is recommended. • Increase awareness and knowledge among youth and children on HIV and AIDS. - Civil society recommends re-introduction of the Adolescent Education Programme in states where it was suspended during the early phase of NACP III.

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**Source URL:** <http://aidsreportingtool.unaids.org/94/india-report-ncpi>