Survey Response Details

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Response Details

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1) Country

India (0)

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

Dr. S. Venkatesh, Deputy Director General,Strategic Information Management Unit National AIDS Control Organisation, Department of AIDS Control, Ministry of Health and Family Welfare,

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Please enter in DD/MM/YYYY format

31/03/2010

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8) Describe the process used for NCPI data gathering and validation:

The National Composite Policy Index draws inputs from active contributors to India's HIV-AIDS response. In reference is the Department of AIDS Control—the apex government body implementing the National AIDS Programme under "Three Ones" - along with PLHIV networks, Civil Society

Organizations (CSO), development partners which include multilateral and bilateral agencies and the UN. The NCPI Part A received inputs from key government officials responsible for implementing and monitoring varied components of the National AIDS Programme. A broad two pronged approach was utilised as means for achieving this end. It involved obtaining written feedback from the Department of AIDS Control's officials heading—and or members—of the following division heads on specific sections of the NCPI Part A: Strategic Information Management Unit (M&E); Care, Support, Treatment and Basic Services; Sexually Transmitted Infection / Reproductive Tract Infections; Blood Safety; Targeted Interventions; Information Education and Communication; and Finance. Key informant interviews were also held with the divisional heads; the Joint Secretary, Department of AIDS Control; and Team Leader, National Technical Support Unit on specific sections of the NCPI Part A. As the government continues encouraging affected communities and individuals living with HIV—the civil society at large—in playing key roles in the national response to the epidemic under "Three Ones;" collaboration on UNGASS was seen essential. With this rationale and to take forward the process of collaboration for monitoring, assessment and course correction; their feedback for NCPI Part B in particular would need to be singular. That is, not influenced by government opinion. Hence a mechanism was developed for this—which is detailed out below—that would leverage the advantage the UNAIDS Secretariat offered with regard to mobilising civil society involvement in UNGASS reporting. Government's direct participation at national level was kept to a minimal and was restricted more towards analysing results or feedback from civil society. In states SACS coordinated state level civil society engagement. This was in keeping with the objective of firmly institutionalising "Three Ones" and considering the diverse civil society and multi-stakeholder engagement for NACPIII implementation present. For gathering data and feedback for NCPI and overseeing data validity; a three step approach was adopted keeping with the goal of maximum stakeholder participation from civil society. As step one 2 regional consultations were executed with civil society organisations (CSO), SACS M&E officers and or Targeted Intervention officers, development partners and UN agencies at Madhya Pradesh and Karnataka in 2009. The objectives are listed below: • To sensitise civil society and partners on development of the UNGASS 2010 progress report; the indicators and reporting process. • Obtain feedback and inputs to UNGASS 2010 India progress report: the NCPI Part B. Use SACS M&E officers' and other officials' presence at the consultation as opportunity to receive feedback on the NCPI Part A. • Ensure civil society involvement in latter stages of report development. Towards this, identify designated CSO representatives who could work with a national working group to support finalisation of the India report. Feedback and civil society inputs emerging from the two regional consultations on NCPI Part B were tabulated. And a process for reconciling scores for a unified national response initiated at centre. The following methodology was utilised for this: • For questions where out of total marks of 5 or 10 a score is asked for: Scores awarded by the 1 group at the Madhya Pradesh consultation and the 3 groups at the Karnataka consultation were averaged out—using a simple average formula —to arrive at a score. • For questions that require response as either "Agree," "Don't Agree," or "NA:" The average response by the 1 group at the Madhya Pradesh consultation and the 3 groups at the Karnataka consultation determined the national response. • For questions where there was need of awarding a percentage (<25%, 25-50%, 51-75% and >75%): A simple average formula was utilised based on the percentage score awarded by the one group at the Madhya Pradesh consultation and the three groups at the Karnataka consultation. • For questions that require response in either the negative or affirmative: The average response was taken to account. There were certain questions for which a national consensus based on the above methods was difficult. In reference are the questions where the response was equally divided. Else, the comments received at the 2 regional consultations were extremely diverse. To give as example, question 7 of the NCPI Part B section on civil society participation reading as: "What percentage of the following HIV programmes / services is estimated to be provided by civil society?" At the consultation in Karnataka, civil society considered their provision of HIV programmes / services to be more robust vis-à-vis the participants at Madhya Pradesh. A reason attributable for this is that as participants attending the Karnataka consultation primarily were from high prevalence states—where the programme is very robust on account of a capacitated SACS, concentrated investment by donor partners and stake holder participation in the states—their involvement and contribution to programme implementation is greater vis-à-vis participants from the low prevalence states attending the Madhya Pradesh consultation. In the Madhya Pradesh consultation the lower score awarded for the same question in point is more on account their own limited capacity rather than lack of will.

The organisations often lack capacity for overall monitoring and evaluation, information gathering, analysis etc. In order to address concerns and reach consensus on the content of NCPI Part B for the India report; a national consultation with civil society representatives was executed. This was step two of the overall strategy for data gathering and validation. Participants at the national consultation were restricted to CSOs—and included those nominated during the two regional consultations—implementing targeted intervention projects for men having sex with men, female sex workers and injecting drug users in Delhi and north-eastern states; development partners and UN agencies. A total of 20 individuals participated at this one day consultation that resulted in discussion and agreement on the content of the NCPI Part B. Based on outcome of discussions at the national consultation, the NCPI Part B was finalised. This version was disseminated through the Solution Exchange for AIDS Community discussion forum for dissemination and receiving comments. This was the third and final step.

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

Regarding the NCPI Part A, to ensure data validity; a screening process was adopted involving dissemination of the draft NCPI Part A to the Secretary and Deputy Director General, Department of AIDS Control; Joint Secretary; Team Leader, National Technical Support Unit—and all heads of divisions of the Department of AIDS Control for comments. A consultation was convened for discussing and finalizing the NCPI Part A content - incorporating revisions if required - and endorsing it. On the NCPI Part B, the process for resolving disagreements included a national consultation with civil society representatives for reviewing first, the harminosed responses to NCPI resultant from their inputs at the regional consultations. Second, review specific questions-where due to the diverse opinion presented at the regional consultations-a clear response was not evident; discuss and arrive at a unanimous agreement.

10)

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

The NCPI Part B data submitted is resultant of inputs from civil society representatives at national, state and district levels. They represents the diverse, numerous civil society organizations who with their capacities, knowledge of the national AIDS programme and level of engagement with Government contribute to HIV-AIDS response. Given this, whilst consensus is reached on the response to questions, their varying opinion is captured in the appropriate comments section. Additionally - and due to differing interpretation of certain questions - information included for certain questions is varying from the NCPI Part B 2008 Country Progress Report if compared.

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11)

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

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	National AIDS Control Organisation, Department of AIDS Control	Mr. K. Chandramouli, Secretary and Director General	A.I, A.II, A.III, A.IV, A.V

12)

			Respondents to

	Organization	Names/Positions	Part A [Indicate which parts each respondent was queried on]
Respondent 2	National AIDS Control Organisation, Department of AIDS Control	Ms. Aradhana Johri, Joint Secretary	A.I, A.II
Respondent 3	National AIDS Control Organisation, Department of AIDS Control	Dr. S. Venkatesh, Deputy Director General,Strategic Information Management Unit	A.V
Respondent 4	National AIDS Control Organisation, Department of AIDS Control	Dr. Damodar Bachani, Deputy Director General, CST & BS Division	A.I, A.IV
Respondent 5	National AIDS Control Organisation, Department of AIDS Control	Dr. Mohammed Shaukat, Assistant Director General (ADG) Blood Safety	A.II
Respondent 6	National AIDS Control Organisation, Department of AIDS Control	Dr. Ajay Khera, Assistant Director General (ADG) Sexually Transmitted Infections (STI) / Reproductive Tract Infections (RTI) Division	A.III
Respondent 7	National AIDS Control Organisation, Department of AIDS Control	Mayank Agarwal, Joint Director (IEC) Information Education and Communication Division	A.II, A.III
Respondent 8	National AIDS Control Organisation, Department of AIDS Control	Dr. Neeraj Dhingra, Assistant Director General(TI) Targeted Intervention Division	A.I, A.III
Respondent 9	National AIDS Control Organisation, Department of AIDS Control	Dr. B. B. Rewari, National Programme Officer (ART) CST and BS Division	A.IV
Respondent 10	National AIDS Control Organisation, Department of AIDS Control	Dr. Suresh Mohammed, National Programme Officer (ICTC) CST and BS	A.I, A.IV
Respondent 11	National AIDS Control Organisation, Department of AIDS Control	Manilal N.R, Programme Officer	A.I, A.IV
Respondent 12	National AIDS Control Organisation, Department of AIDS Control	Aditya Singh, Technical Officer Targeted Intervention Division	A.I, A.IV
Respondent 13	National AIDS Control Organisation, Department of AIDS Control	Bilal Ahmed, Technical Officer (IEC)	A.II, A.III
Respondent 14	National AIDS Control Organisation, Department of AIDS Control	Madhu Sharma, Project Officer Information Education & Communication Division	A.II, A.III
Respondent	National AIDS Control Organisation,	Ugra Mohan Jha, Programme Monitoring Officer,	A.I, A.II, A.V

15	Department of AIDS Control	Strategic Information Management Unit	A.I, A.II, A.V
Respondent 16	Andra Pradesh SACS	S. Ravi, M&E Officer	A.I, A.II, A.V
Respondent 17	Chhattisgarh SACS	Sarwant Hussain Naquvi, Programme Officer Strategic Management Unit	A.I, A.II, A.V
Respondent 18	Gujarat SACS	Pradeep Kumar, Additional Project Director	A.I, A.II, A.V
Respondent 19	Goa SACS	Victoria D'Lima, Civil Society Consultant	A.I, A.II, A.V
Respondent 20	IHAT TSU	John Anlhmig, Team Leader	A.I, A.II, A.V
Respondent 21	KHPT	Parinita, Director Programmes	A.I, A.II, A.V
Respondent 22	KHPT	Dr. Reynold Washington, Director	A.I, A.II, A.V
Respondent 23	Karnataka SAPS	Vineesh C. R, IDU Project Manager	A.I, A.II, A.V
Respondent 24	Karnataka SAPS	Bhuvan Chander M	A.I, A.II, A.V
Respondent 25	Karnataka SAPS	Chandrakanta, Joint Director TI	A.I, A.II, A.V

13) **If the number of respondents to Part A is more than 25, please enter the rest of respondents for Part A in below box.**

KSAPS - M Naine Ram, Deputy Director - A.I, A.II, A.V KSAPS - R R Jannu, Programme Director - A.I, A.II, A.V KSAPS - S B Dodamani, Deputy Director (M&E) HIV/TB surveilance - A.I, A.II, A.V KSAPS - S S Prakasu, Additional Project Director - A.I, A.II, A.V KSAPS - Srinivas - A.I, A.II, A.V KSAPS - Suresh V. Shellikeri, Deputy Director Blood Safety- A.I, A.II, A.V KSAPS - Thippeswamy B C - A.I, A.II, A.V KSAPS - Vijay Hughe, M&E Officer - A.I, A.II, A.V KSAPS - Virupaksha K - A.I, A.II, A.V MP SACS - D. M. Saxena, Epidemiologist - A.I, A.II, A.V MP SACS - Omesh Mundra, Programme Director - A.I, A.II, A.V MP SACS - Smita Shendya, Team Leader Technical Resource Group - A.I, A.II, A.V MP SACS - Sunila S. Raja, CCSM - A.I, A.II, A.V MP SACS TSU - Apurva Chaturvedi, Team Leader Strategic Planning - A.I, A.II, A.V MP SACS TSU - Shilpi Agnani, Advocacy Officer - A.I, A.II, A.V MPSACS - Shraddha Bose, Joint Director IEC - A.I, A.II, A.V TANSACS - R. Vender Vendan, Joint Director Targeted Intervention - A.I, A.II, A.V

14)

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

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	Action Aid	K. Manjula, Programme Officer	B.I, B.II, B.III, B.IV

15)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent	Action Aid	Manish Kumar, Central	B.I, B.II, B.III, B.IV

2	Action Aid	Coordinator	B.I, B.II, B.III, B.IV
Respondent 3	Ashodaya Samithi	Bhagyalakshmi, Secretary	B.I, B.II, B.III, B.IV
Respondent 4	Aurnodalya Sansriti	V. S. Vasuki, Secretary	B.I, B.II, B.III, B.IV
Respondent 5	BPNP+	Bala, Counsellor	B.II, B.III, B.IV
Respondent 6	BPNP+	Vineeta Sahu, District Network Officer	B.II, B.III, B.IV
Respondent 7	Butterfly Nature Club of India	Avnish Jolly	B.I, B.II, B.III, B.IV
Respondent 8	Community Care Centre - Maitri	C. Narayan, Janitor	B.II, B.III, B.IV
Respondent 9	Community Care Centre - Maitri	Rajendra, Outreach worker	B.II, B.III, B.IV
Respondent 10	CDC	Deepika Joshi, Strategic Information Advisor	B.I, B.II, B.III, B.IV
Respondent 11	Clinton Foundation	Lalitha Hande R., Regional Manager South India	B.I, B.II, B.III, B.IV
Respondent 12	Clinton Foundation	Milie Mishra,	B.I, B.II, B.III, B.IV
Respondent 13	Clinton Foundation	Vijay Talwar, Chief Executive Officer	B.I, B.II, B.III, B.IV
Respondent 14	Consultant (Independent)	Snehansu Bhaduri	B.I, B.II, B.III, B.IV
Respondent 15	Disha	Venugopal M S, Project Officer	B.I, B.II, B.III, B.IV
Respondent 16	Emanuelle Hospital Association - Project Orchid	Ching H Songput, State Manager	B.I, B.II, B.III, B.IV
Respondent 17	EngenderHealth	Lloyd T. Cunningham, OVC Specialist	B.I, B.II, B.III, B.IV
Respondent 18	EngenderHealth	Vikas Inamder, HIV-TB Specialist	B.I, B.II, B.III, B.IV
Respondent 19	FHI	Srinivas	B.I, B.II, B.III, B.IV
Respondent 20	Freedom Foundation	K. V. Madhuri, Project Manager	B.I, B.II, B.III, B.IV
Respondent 21	Gandhi Bhawan	Sudhir Kumar, Project Director	B.II, B.III, B.IV
Respondent 22	Jeevana Sanskriti	J J Pallath, Project Manager	B.II, B.III, B.IV
Respondent 23	KPWN+	Bindu P. B	B.I, B.II, B.III, B.IV
Respondent 24	KNP+	P. Saroja, President	B.I, B.II, B.III, B.IV
Respondent 25	LEPRA Society	Kavita Chauhan, Project Manager	B.II, B.III, B.IV

16) If the number of respondents to Part B is more than 25, please enter the rest of respondents for Part B in below box.

LEPRA Society - Raj Kumar Rai, State Liaison Officer - B.I, B.II, B.III, B.IV Lions Blood Bank - Deepak Suman, Coordinator - B.I, B.II, B.III, B.IV Mahila Chetna Munch - Nirmala Buch, President- B.II, B.III, B.IV Mahila Chetna Munch - Sameer Chaturvedi, Programme manager - B.II, B.III, B.IV Myrada - Maya Mascherenas, Project Coordinator - B.I, B.II, B.III, B.IV North East India Harm Reduction Network / Care Foundation - Ronny Waikhom, Executive Director Care Foundation - B.I,

B.II, B.III, B.IV Pahal Foundation - Yashwinder Singh - B.I, B.II, B.III, B.IV Positive People - Sonia Das, Programme manager - B.I, B.II, B.III, B.IV Pratigya Vikas Sansthan - R. S. Mishra, Project Director - B.I, B.II, B.III, B.IV PSI - Sapna, State Programme Manager - B.I, B.II, B.III, B.IV PWN+ - P Kousalya, President - B.I, B.II, B.III, B.IV Rajeev Smriti - Anil Ansare, Counsellor - B.II, B.III, B.IV Rajeev Smriti - Gyanendra Mohan, Project Manager - B.II, B.III, B.IV Rashtrotthana Blood Bank - Sumitra P., Medical Officer - B.I, B.II, B.III, B.IV Rishta Project - Sofia Calderia, Programme manager - B.I, B.II, B.III, B.IV SAHAS - Vibha Marfatia, Director - B.I, B.II, B.III, B.IV Sahodaran - Sunil Menon- B.I, B.II, B.III, B.IV Samraksha - Sanghamitra Iyengar, Director - B.I, B.II, B.III, B.IV Sardarmunch Mitra Bhawan - M. R. Kanani, Project Manager - B.II, B.III, B.IV SCHOD Society - K. Ganesh, Director - B.I, B.II, B.III, B.IV Sewa Bharti - Dipti Chourey, Psychologist - B.II, B.III, B.IV Sewa Bharti - Kamla Tripathi, Auxilliary Nurse Midwife - B.I, B.II, B.III, B.IV Sewa Bharti - Manish Saxena, Project Manager - B.II, B.III, B.IV Shabhagini - Shanthamma, Front Operation Manager - B.I, B.II, B.III, B.IV SHELTER - Gopalakrishnan - B.I, B.II, B.III, B.IV SIP+ - Dhanam, Programme Coordination Officer - B.I, B.II, B.III, B.IV Snehadaan - Mathew Perumpil, Director- B.I, B.II, B.III, B.IV SPYM - Rajesh Kumar - B.I, B.II, B.III, B.IV SVYM - Balasubramanya, Chief Executive Officer - B.I, B.II, B.III, B.IV Swasti - Chandrashekhar Gowda, Manager - B.I, B.II, B.III, B.IV Swati Mahila Sangha - Pushpa Lata - B.I, B.II, B.III, B.IV TASA - M. Shiamla Baby, Director Forward - B.I, B.II, B.III, B.IV UNAIDS - Binod Mahanty, M&E Officer - B.I, B.II, B.III, B.IV UNAIDS - Charles Gilks, India Country Coordinator - B.I, B.II, B.III, B.IV UNAIDS - Nalini Chandra, Consultant - B.I, B.II, B.III, B.IV UNAIDS - Nandini Kapoor Dhingra, Senior National Programme Coordinator - B.I, B.II, B.III, B.IV UNAIDS - Taoufik Bakkali, Senior M&E Advisor - B.I, B.II, B.III, B.IV UNICEF - Bhai Shelly, Programme communication Specialist - B.I, B.II, B.III, B.IV UNICEF - Hamid El- Bashir, Madhya Pradesh State Representative - B.I, B.II, B.III, B.IV UNICEF - Ivonne Camaroni, Chief HIV-AIDS - B.I, B.II, B.III, B.IV UNICEF - S. Shrivastava, HIV Consultant - B.I, B.II, B.III, B.IV UNICEF - Sanjay, Consultant - B.II, B.III, B.IV USAID - Sangeeta Kaul - B.I, B.II, B.III, B.IV Vijaya Mahila Sangha - Geetha, Director - B.II, B.III, B.IV Vijaya Mahila Sangha - Rajani, President - B.II, B.III, B.IV WFP - U S Sharma, Officer in Charge - B.II, B.III, B.IV

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17)

Part A, Section 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 (0)

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18) **Part A, Section I: STRATEGIC PLAN**

Question 1 (continued)
Period covered:

1991 - 2009

19)

1.1 How long has the country had a multisectoral strategy?

Number of Years

18

20)

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

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	Yes
Transportation	Yes	Yes
Military/Police	Yes	Yes
Women	Yes	Yes
Young people	Yes	Yes
Other*	Yes	Yes

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21) **Part A, Section I: STRATEGIC PLAN**

Question 1.2 (continued)
If "Other" sectors are included, please specify:

Ministry of Railways, Ministry of Tourism, Ministry of Rural Development, Ministry of Panchayati Raj, Ministry of Tribal Affairs

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22)

Part A, Section I: STRATEGIC PLAN

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex workers	Yes
f. Orphans and other vulnerable children	Yes
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	

k.HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

23)

1.4 Were target populations identified through a needs assessment?

Yes (0)

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24)

Part A, Section I: STRATEGIC PLAN

Question 1.4 (continued)
IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2006

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25)

Part A, Section I: STRATEGIC PLAN

1.5 What are the identified target populations for HIV programmes in the country?

The identified target populations for HIV programmes includes HRG, bridge populations—which in India refer to short stay migrants and truckers—and 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.

26)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

27)

1.7 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?	Yes
e. A monitoring and evaluation framework?	Yes

28)

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement (0)

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29)

Part A, Section I: STRATEGIC PLAN

Question 1.8 (continued)
IF active involvement, briefly explain how this was organised:

The participation of CSO in the development and implementation of the multi-sectoral strategy has been robust. A working group on youth and mainstreaming was formed in April 2005 for the development of multi-sectoral strategy. The working group had representation from CSO including PLHIV network representatives, independent experts, UN, and development partners. The multisectoral strategy was incorporated to the NACP III based on the recommendations of the working group. Civil society representatives continue to be involved in future planning through their participation in TRG that advice the government. They are also members of the Country Coordinating Mechanism that guides and oversees GFATM investment in the country.

30)

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

31)

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners (0)

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32)

Part A, Section I: STRATEGIC PLAN

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 (0)

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33)

Part A, Section I: STRATEGIC PLAN

2.1 *IF YES*, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes
b. Common Country Assessment / UN Development Assistance Framework	Yes
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	Yes
e. Other: Ministries of Panchayati Raj, Rural Development, Tribal Affairs	Yes

34)

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

HIV-related area included in development plan(s)	
HIV prevention	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security or other schemes)	Yes
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	No
Reduction of stigma and discrimination	Yes
Women's economic empowerment (e.g. access to credit, access toland, training)	Yes
Other: Please specify	

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35)

Part A, Section I: STRATEGIC PLAN

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

Yes (0)

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36)

Part A, Section I: STRATEGIC PLAN

3.1 *IF YES*, to what extent has it informed resource allocation decisions?

5 (5)

37)

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 (0)

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38)

Part A, Section I: STRATEGIC PLAN

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: ICTC and PMTCT centre scale up	Yes

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39)

Part A, Section I: STRATEGIC PLAN

Question 4.1 (continued)
If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

The National AIDS Control Programme III (NACP III) provides technical assistance to train health care staff at ICTC and ART centres in prisons. The emphasis is on HIV prevention in the uniformed services. For this people are encouraged to go for testing. The uniformed services do not discriminate against people who test positive. The Ministry of Home Affairs (Internal Security) has set up a task force with representation from various Central Paramilitary Forces. A Consolidated Action Plan—with a budget allocation of USD 3.5 million—is being implemented for HIV-AIDS prevention, care and treatment. Almost 180 ICTC with rapid diagnostic test kit facility are setup; 239 condom vending machines installed; and 270,838 condoms distributed. The Ministry of Defence has established 20 ICTC centres. PMTCT services are provided through Ministry of Defence budget at all antenatal care clinics.

40)

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

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41)

Part A, Section I: STRATEGIC PLAN

5.1 *IF YES*, for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	No
f. Prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	

42)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Although there are many implementation challenges; efforts are underway for protecting most at risk and vulnerable populations. The Constitution of India guarantees right to life, health and equality to all citizens. Government policies such as the National AIDS Prevention and Control Policy (NAPCP) 2002 espouse a human response. An HIV/AIDS Prevention Bill 2007 was drafted through the joint initiative of the government and civil society (in particular the Lawyers Collective). The Bill embodies principles of Human Rights and seeks to establish a humane and egalitarian legal regime to support India's prevention, care and treatment support efforts vis-à-vis the epidemic.

43)

Briefly comment on the degree to which these laws are currently implemented:

Although India has the National AIDS Prevention and Control Policy (NAPCP) 2002, this does not have the status of law and is not binding or enforceable in Court. Therefore if a person were to claim that she lost her job because she is HIV positive, she cannot seek remedy through the mechanism of the Policy. The existence of a nationally applicable statute would lend clarity and consistency in order for courts to effectively pass judgement in HIV and AIDS cases.

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44)

Part A, Section I: STRATEGIC PLAN

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

Page 22

45)

Part A, Section I: STRATEGIC PLAN

6.1 *IF YES,* for which subpopulations?

a. Women	No

b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	No
Other: Please specify	

46)

IF YES, briefly describe the content of these laws, regulations or policies:

The laws, regulations or policies that present obstacles of effective HIV prevention, treatment, care and support are: - In India, Section 377 of the Indian Penal Code, 1860 criminalises sodomy, widely interpreted as criminalising sex between men. - Sex Work per se is not illegal in India. Brothel based prostitution however in public places such as street, highways or parks is an offence. - Under the Narcotic Drugs and Psychotropic Substances (NDSP) Act, 1985, the provision of sterile needles may amount to abetment of illicit drug consumption. - Section 299 of the Indian Penal Code prohibits production/ distribution of materials which could be obscene.

47)

Briefly comment on how they pose barriers:

These laws pose barriers to effective implementation of the National HIV-AIDS programme as explained below: - Section 377 of the Indian Penal Code, 1860 criminalises sodomy, widely interpreted as criminalizing sex between men. In addition to the social stigma related to homosexuality, Section 377 had driven men having sex with men underground. This has hindered their access to health and other public services, created an environment of denial and neglect, and driven them into spaces that encourage furtive, unsafe sexual activity. Many men having sex with men in India are married, which increases the vulnerability of their spouses to HIV. Additionally, peer outreach workers may be threatened for abetting men having sex with men activity and condom distribution may be construed illegal especially in prisons and other institutional settings with the male population. Finally, blackmail and sexual abuse is likely to go unreported thereby leading to human rights violations for MSM and male sex workers. On 2 July 2009, the Delhi High court in a landmark judgement read down Section 377 which decriminalising consensual sex between adult men. The judgement however is challenged in the Supreme Court. NACO is collaborating with civil society groups such as Lawyers Collective, NAZ Foundation for advocating in favour of the Delhi High Court Judgement. - As brothel based prostitution in public places such as street, highways or parks is an offence; it affects outreach and condoms distribution amongst the population group. - The Narcotic Drugs and Psychotropic Substances (NDSP) Act, 1985, can pose a major barrier to the scale up of the Needle Syringe Exchange Programme. - As Section 299 of the Indian Penal Code prohibits production/ distribution of materials which could be obscene; the safer sex IEC material developed under the AEP may be questioned under this provision.

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48)

Part A, Section I: STRATEGIC PLAN

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes (0)

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49)

Part A, Section I: STRATEGIC PLAN

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes (0)

50)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

51)

Part A, Section I: STRATEGIC PLAN

7.3 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 (0)

52)

7.4 Is HIV programme coverage being monitored?

Yes (0)

Page 26

53)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

54)

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

Yes (0)

Page 27

55)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (b) (continued)
IF YES, for which population groups?

HIV and AIDS programme coverage is monitored by sex and population groups. The information is captured at facility level for ART coverage. Currently the reporting formats are being modified to get this information every month from all the ART facilities. The coverage for care, support and treatment is monitored by sex and age. Systems for accessing gender disaggregated data are being set up for monitoring programme coverage for prevention programmes.

56)

Briefly explain how this information is used:

This information, when available, will be used for improved programme planning for prevention programmes for HRG through Targeted Interventions. In addition, the program regularly receives ICTC data which is used for forecasting people who will need ART in the future.

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57) **Part A, Section I: STRATEGIC PLAN**

Question 7.4 (continued)
(c) Is coverage monitored by geographical area?

Yes (0)

Page 29

58)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (c) (continued)
IF YES, at which geographical levels (provincial, district, other)?

The ART coverage is monitored geographically at the state and district level.

59)

Briefly explain how this information is used:

The ART coverage data has been analyzed and used for instituting LAC for follow up care, adherence counseling and drug dispensing services for people initiated on ART.

60)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

Page 30

61)

Part A, Section I: STRATEGIC PLAN

Question 7.5 (continued)
Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

8 (8)

62)

Since 2007, what have been key achievements in this area:

Program managers at NACO are constantly reviewing data for high risk groups to fine tune the programme implementation strategy. Over the past two years, HIV prevalence rate among female sex workers has reduced while it has increased among IDU. Migrants are another vulnerable group that has emerged as a priority. These facts have been taken into account while planning the 2010 strategy. The Joint mid term review (MTR)of the NACP III conducted in November - December 2009 with development partners provided a wealth of strategic information and operations research data for HIV/AIDS strategy planning for the upcoming fourth phase of the NACP.

63)

What are remaining challenges in this area:

One of the key challenges has been the limited capacity of some states to implement the programme at the decentralised level. This challenge is being address through: i) centralised contracting system for prevention commodities such as condoms, and ii) setting up institutional mechanisms at state level through the STRC & TSU.

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64)

Part A, Section II: POLITICAL SUPPORT

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

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

65)

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

Yes (0)

Page 32

66)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

2005

67)

2.2 IF YES, who is the Chair?

Name	Dr. Manmohan Singh
Position/title	The Prime Minister of India

68)

2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	Yes
have an action plan?	Yes
have a functional Secretariat?	Yes
meet at least quarterly?	No
review actions on policy decisions regularly?	Yes
actively promote policy decisions?	Yes
provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes

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69)

Part A, Section II: POLITICAL SUPPORT

Question 2.3 (continued)
If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

53

70)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

15

71)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?

Please enter an integer greater than or equal to 1

2

Page 34

72)

Part A, Section II: POLITICAL SUPPORT

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 (0)

Page 35

73)

Part A, Section II: POLITICAL SUPPORT

Question 3 (continued)
IF YES, briefly describe the main achievements:

There are various mechanisms to promote interaction between government, civil society and private sector. Notably a significant part of the Prevention program for Most at risk populations through the TI approach (1247 interventions) is implemented through the civil society in NACP III. CSO are engaged in delivering care and support services through community care centres funded through NACP III. Approximately 14 TRG were set up to provide advice on strengthening various programme components. A range of CSO representatives are members of TRG including NGO, networks of PLHIV, CBO of female sex workers and man having sex with men and faith based organizations. CSO are members of the NCA and also in selected State Council for AIDS.

74)

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

Please enter the rounded percentage (0-100)

35

75)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	

76)

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

Yes (0)

Page 36

77)

Part A, Section II: POLITICAL SUPPORT

6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

No (0)

Page 38

78)

Part A, Section II: POLITICAL SUPPORT

Question 6.1 (continued)
Overall, how would you rate the political support for the HIV programmes in 2009?

8 (8)

79)

Since 2007, what have been key achievements in this area:

Political support for the National Programme is quite high. The Joint Parliamentary Forum on AIDS at national level and State Legislative Forums on AIDS in approximately 20% 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.

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80)

Part A, Section III: PREVENTION

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

Yes (0)

Page 40

81)

Part A, Section III: PREVENTION

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)
c. Be faithful (0)
d. Reduce the number of sexual partners (0)
e. Use condoms consistently (0)
f. Engage in safe(r) sex (0)
g. Avoid commercial sex (0)
h. Abstain from injecting drugs (0)
i. Use clean needles and syringes (0)
j. Fight against violence against women (0)
k. Greater acceptance and involvement of people living with HIV (0)
l. Greater involvement of men in reproductive health programmes (0)
m. Males to get circumcised under medical supervision (0)
n. Know your HIV status (0)
o. Prevent mother-to-child transmission of HIV (0)

82)

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

Yes (0)

Page 41

83)

Part A, Section III: PREVENTION

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

84)

2.1 Is HIV education part of the curriculum in:

primary schools?	No
secondary schools?	Yes
teacher training?	Yes

85)

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

86)

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

Yes (0)

87)

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

Yes (0)

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88)

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Sex workers, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
Vulnerability reduction (e.g. income generation)	
Drug substitution therapy	Injecting drug user, Prison inmates
Needle & syringe exchange	Injecting drug user

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89) **Part A, III. PREVENTION**

Question 3.1 (continued)
You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

Other populations refers to migrants and truckers.

Page 44

90)

Part A, III. PREVENTION

Question 3.1 (continued)
Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

7 (7)

91)

Since 2007, what have been key achievements in this area:

One of the core priorities under the NACP III is HIV prevention. Considering that over 99% of the population is not infected, the focus is towards integrating prevention with care, support and treatment efforts. Sub-populations that have higher risk for HIV such as sex workers, men having sex with men and injecting drug users will receive priority for interventions. This is followed by groups which have high levels of exposure to HIV such as truckers, migrants, prisoners and street children. Those in the general population who have greater need for accessing prevention services such as STI treatment, voluntary counseling and testing and condoms will be next in the line of priority.

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92)

Part A, III. PREVENTION

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

Yes (0)

Page 46

93)

Part A, III. PREVENTION

Question 4 (continued)
IF YES, how were these specific needs determined?

The country is making every effort to ensure that all sub populations at elevated risk receive all services necessary for risk mitigation. Work further advanced in respect with FSW and MSM populations in comparison with injecting drug users.

94)

4.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out-of-school young people	Agree
HIV prevention in the workplace	Agree
Other: please specify	

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95)

Part A, III. PREVENTION

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

8 (8)

96)

Since 2007, what have been key achievements in this area:

The key achievements in this area are: NACO has achieved significant scale up of TI. There is increased focus on referring HRG to ICTC and ART. High quality training modules is developed and a robust MIS system is established.

97)

What are remaining challenges in this area:

The main challenges are: Flexibility in intervention approaches and strategies will be necessary to reach sub-groups and difficult to reach high risk gropus in varying geographies and settings - beyond the urban and semi-urban areas. Scaling up men having sex with men programmes remains a challenge due to lack of relevant experience among the NGO in this area. The slow pace of OST roll out has impacted early intervention among injecting drug users. The planned transition of OST services from experienced NGO to the public sector will require more time and is

likely to reduce the accessibility and acceptability of these crucial harm reduction services.

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98)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes (0)

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99)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1.1 IF YES, does it address barriers for women?

Yes (0)

100)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

101)

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

Page 50

102)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 2 (continued)
IF YES, how were these determined?

This is a consultative process with stake holders, development partners and technical resource group.

103)

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

	The majority of people in need have access

HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Don't agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree
HIV care and support in the workplace (including alternative working arrangements)	Agree
Other: please specify	

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104)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes (0)

105)

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes (0)

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106)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 4 (continued)
IF YES, for which commodities?:

All ARV drugs are procured annually following 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 installments. 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.

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107)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

8 (8)

108)

Since 2007, what have been key achievements in this area:

The key achievements in this area are: The implementation of CST has been very successful . With the exception of paediatric ART, most of the targets set under NACP III are on course, while some are likely to be exceeded (example: 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 Centres, Centres of Excellence). Over time, new activities have been added such as the introduction of the LAC, 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, CCC 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. □ Smart card: The smart card was piloted successfully and will roll out by June 2010.

109)

What are remaining challenges in this area:

The main challenges in this area are: □ Despite the rapid expansion of ART, LAC and CCC, monitoring and supervision capacities have not increased proportionality. □ Whilst 35% of positive ICTC / TI clients (cumulative) do not register at the ART centers; 17% of people who register come in with a CD4 count of less than 50. □ There is no appropriate take-home IEC material for illiterate and less educated clients of the ART centers. They represent 65% of all ART users. □ 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. □ The implementation success of CCC is variable across the country and its role unclear. Assessment of existing CCC as planned by NACO will bring clarity to the functions. □ Access to ART by HRG is estimated to be low although the current system does not allow accurate monitoring. Capacity to counsel HRG at ART center is limited. □ There is no formal mechanism to monitor confidentiality issues. With the increasing number of adolescents enrolled on ART, appropriate adolescent counseling becomes necessary. □ Monitoring drug resistance remains a challenge. □ It is unlikely that the program will reach the target for the number of children alive and on ART. Targets need to be revisited based on updated information about PPTCT coverage. Data also reveal that in all states, except the North East, there is a remarkable

difference of access to ART services by children according to the gender. In addition, approximately 5% of children on treatment are lost to follow up or missing due to lack of adherence, migration or death.

Page 54

110)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

Page 55

111)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

112)

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

No (0)

113)

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

No (0)

Page 56

114)

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

5 (5)

115)

Since 2007, what have been key achievements in this area:

There is significant scale up of availability and access to ART by Children Living with (CLHIV). There are also many more programmes on the ground for care and support of Children Affected by HIV-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.

116)

What are remaining challenges 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 remain.

Page 57

117)

Part A, Section V: MONITORING AND EVALUATION

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

Yes (0)

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118)

1.1 IF YES, years covered:
Please enter the start year in yyyy format below

2007

119)

1.1 IF YES, years covered:
Please enter the end year in yyyy format below

2009

120)

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

121)

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes (0)

122)

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

Yes, most partners (0)

Page 60

123)

Part A, Section V: MONITORING AND EVALUATION

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	No
a data analysis strategy	No
a data dissemination and use strategy	No

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124)

Part A, Section V: MONITORING AND EVALUATION

Question 2 (continued)
If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	

125)

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

Yes (0)

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126)

Part A, Section V: MONITORING AND EVALUATION

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

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

4

127)

3.2 IF YES, has full funding been secured?

Yes (0)

128)

3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

Page 64

129)

4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

Page 65

130)

Part A, Section V: MONITORING AND EVALUATION

Question 4 (continued)
IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

National M&E system assessment is conducted every two years. It involves the appraisal of the M&E plan, data management capacities and the reporting systems—and on which basis—an action plan is developed for addressing identified weaknesses at all three levels. The three levels in question are the M&E plan, data management capacities and reporting systems. Priorities for M&E are determined through programme level data and the Joint Implementation Reviews. Although all components of the plan are reviewed individually, there is no comprehensive M&E assessment strategy.

131)

5. Is there a functional national M&E Unit?

Yes (0)

Page 66

132)

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)? Yes
in the Ministry of Health?
Elsewhere? (please specify)

133) **Number of permanent staff:**

Please enter an integer greater than or equal to 0

1

134) **Number of temporary staff:**

Please enter an integer greater than or equal to 0

8

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135)

Part A, Section V: MONITORING AND EVALUATION

Question 5.2 (continued)
Please describe the details of all the permanent staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Permanent staff 1	Deputy Director General	Full time	
Permanent staff 2			
Permanent staff 3			
Permanent staff 4			
Permanent staff 5			
Permanent staff 6			
Permanent staff 7			
Permanent staff 8			
Permanent staff 9			
Permanent staff 10			
Permanent staff 11			
Permanent staff 12			
Permanent staff 13			
Permanent staff 14			
Permanent staff 15			

136)

Please describe the details of all the temporary staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Temporary staff 1	M&E Programme Officer	Full time	
Temporary staff 2	M&E Officer	Full time	
Temporary staff 3	M&E Officer	Full time	
Temporary staff 4	M&E Officer	Full time	
Temporary staff 5	M&E Officer	Full time	
Temporary staff 6	M&E Officer	Full time	
Temporary staff 7	M&E Officer	Full time	
Temporary staff 8	M&E Officer	Full time	
Temporary staff 9			
Temporary staff 10			
Temporary staff 11			
Temporary staff 12			
Temporary staff 13			
Temporary staff 14			
Temporary staff 15			

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137)

Part A, Section V: MONITORING AND EVALUATION

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes (0)

Page 69

138) **Part A, Section V: MONITORING AND EVALUATION**

Question 5.3 (continued)
IF 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 firstly, the Computerized Management Information System (CMIS). Secondly, data sharing guidelines are developed and placed on the NACO website for free access to all institutions/organizations/stakeholders. Anyone can complete the data sharing request form and apply for data access. This request, once reviewed by the NACO officer is transferred to the designated approving authority which will authorize access.

139)

What are the major challenges?

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 with others. There are three major challenges. Firstly, there is no standard reporting format for feeding data. Secondly, there is no standard definition for the indicators. Finally, data disaggregation by age groups is difficult to obtain from the field.

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140)

Part A, Section V: MONITORING AND EVALUATION

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

Yes, meets regularly (0)

141)

6.1 Does it include representation from civil society?

No (0)

Page 71

142)

7. Is there a central national database with HIV- related data?

Yes (0)

Page 72

143)

Part A, Section V: MONITORING AND EVALUATION

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

The national database is the Computerized Management Information System. It is managed by the M&E unit of NACO.

144)

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above (0)

Page 73

145)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 74

146) **Part A, Section V: MONITORING AND EVALUATION**

For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

For Question 7.3, you have indicated "Yes" to "subnational level", please specify 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.

147)

8. Does the country publish at least once a year an M&E report on HIV, including HIV

surveillance data?

Yes (0)

148)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

5 (5)

149)

Provide a specific example:

M&E data is used widely to inform / facilitate in evidence based planning. For example, M&E data is utilised for developing the framework for district re-prioritization. It was the basis for development of the migrant strategy and for refocusing the care and treatment programme.

150)

What are the main challenges, if any?

The challenges include issues related to data quality, data validation, data analysis and relevance of data that is collected.

Page 75

151) **Part A, Section V: MONITORING AND EVALUATION**

9.2 To what extent are M&E data used for resource allocation?

5 (5)

152)

Provide a specific example:

M&E data is used to determine human resource requirement at treatment, care and support centres. If the client load is very high at an ICTC centre, for example, the number of counsellors is increased. M&E data is used also for identifying data gaps and initiating operational research studies for programme improvement.

153)

What are the main challenges, if any?

Challenges include quality of mapping data and high turnover of staff.

Page 76

154)

Part A, Section V: MONITORING AND EVALUATION

9.3 To what extent are M&E data used for programme improvement?:

5 (5)

155)

Provide a specific example:

M&E data is used for programme improvement, particularly for the following: 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.

156)

What are the main challenges, if any?

The main challenge is over data quality.

Page 77

157) **Part A, Section V: MONITORING AND EVALUATION**

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, at all levels (0)

Page 78

158)

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

At national level?	Yes
At subnational level?	Yes
At service delivery level including civil society?	Yes

Page 79

159) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.1 (continued)
Please enter the number of people trained <u>at national level.</u>

Please enter an integer greater than 0

495

160) **Please enter the number of people trained <u>at subnational level.</u>**

Please enter an integer greater than 0

2535

161) **Please enter the number of people trained <u>at service delivery level including civil society.</u>**

Please enter an integer greater than 0

12393

Page 80

162)

Part A, Section V: MONITORING AND EVALUATION

10.2 Were other M&E capacity-building activities conducted other than training?

Yes (0)

Page 81

163) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
IF YES, describe what types of activities:

The following was conducted: □ Data triangulation for NACP III mid-term review. □ District AIDS Prevention Control Units training. □ Training on SPSS and MIS □ Programme management and HR management capacity development workshops conducted for project directors and programme staff.

Page 82

164) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
Overall, how would you rate the M&E efforts of the HIV programme in 2009?

9 (9)

165)

Since 2007, what have been key achievements in this area:

The key achievements since 2007 are the following: □ Establishment of SIMU and development of the SIMU manual and guidelines. □ Core indicators developed and defined. □ Mapping of most at risk population groups for revised estimates. □ Strategic planning for the Annual Action Plan based on programme data.

166)

What are remaining challenges in this area:

Challenges include: □ There should be a common reporting platform and software for all stakeholders to use. □ SIMS and Smart Card System are yet to be instituted.

Page 83

167)

Part B, Section I: HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

Yes (0)

Page 84

168)

Part B, Section I. HUMAN RIGHTS

1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general nondiscrimination provision:

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 (PLHIV): □ 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. Whilst these Fundamental Rights form basis for NACO to take forward issues of PLHIV discrimination; there are steps being undertaken for introducing new pertinent laws in favour of PLHIVs . For example, the 2005 HIV-AIDS Bill which is drafted with PLHIVs' active support. The HIV-AIDS Bill does incorporate provisions against PLHIVs' discrimination and is in favour of their right to schooling, employment, health care etc. The process of tabling the Bill in Parliament has extended to four years, however, and the reason for this was allowing in-depth review and discussion by key stakeholder groups. Certain sections of civil society have advocated for the reintroduction of certain clauses-that are in favour of PLHIVs-and included in the initial version of the bill. It is anticipated that the Bill will be tabled in 2010. The Juvenile Justice Act, 2000 includes in its definition of 'Child in need of Protection who is entitled to Government support for Housing and Education' children infected with HIV-AIDS. There is, however, yet to be a documented case of a child infected with HIV-AIDS seeing Government support on its basis. The Integrated Child Protection Scheme is formulated for advancing the Legislative Objective of the Juvenile Justice Act. To note firstly, that at the Bangalore consultation the response to this question was in the negative whilst at Madhya Pradesh it was in the affirmative. Consensus on this question's response was arrived at the national consultation at New Delhi. Secondly, in the 2008 report the answer to the question was in the negative possibly due to different understanding of the question.

169)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 85

170)

Part B, Section I. HUMAN RIGHTS

2.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	

171)

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

India has non-discrimination laws for protecting rights and interests of women and children. These are guaranteed to all through Articles 15 and 16 of the Indian Constitution and the Juvenile Justice Act.

172)

Briefly describe the content of these laws:

The laws in place for protection of women and young people's rights and interests is described below. The Constitution of India provides protection to all citizens—irrespective of age, gender, caste and class. These are constitutional safeguards against discrimination. This covers PLHIV on matters of public employment and to some extent health care. The reading down of Section 377 by Delhi High Court which decriminalises of 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.

173)

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

Whist these laws are in place, the degree with which they are implemented could be strengthened.

Page 86

174)

Part B, Section I. HUMAN RIGHTS

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 87

175)

Part B, Section I. HUMAN RIGHTS

3.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	No
Other: Transgenders	Yes

176)

IF YES, briefly describe the content of these laws, regulations or policies:

The legal provisions that act as obstacles for reaching most at risk populations are below: The Immoral Traffic (Prevention) Act 1956 or ITPA which regulates sex work while penalizing trafficking or procurement and detention in organized sex work. Section 377 of the Indian Penal Code considers unnatural offences 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 Narcotic Drugs and Psychotropic Substances Act, 1985 or NDPS sets out the legal framework for drug control. One of the most stringent laws in the country, the NDPS proscribes production, cultivation, manufacture, sale, possession and consumption of cannabis, opium, cocaine as well as other psychotropic substances as illegal.

177)

Briefly comment on how they pose barriers:

The Immoral Traffic (Prevention) Act 1956 or ITPA, Section 377 of the Indian Penal Code and the Narcotic Drugs and Psychotropic Substances Act, 1985 or NDPS pose barriers for effective HIV prevention, treatment, care and support for most at risk and vulnerable populations as highlighted below: The legal provisions that act as obstacles for reaching most at risk populations are below: ITPA 1986: 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. In May 2007, the Ministry of Women and Child Development proposed certain amendments to the ITPA in the upper house of the Parliament amidst opposition from quarters within and outside the Government. The ITPA Amendment Bill sought to change Legislative Policy on sex work from tolerance to prohibition. This was being considered through punishment of persons visiting brothels, that is, clients of sex workers. The Bill inserted a new definition of trafficking, to criminalize poverty induced sex work. The ITPA Amendment Bill received strong opposition from the CSO, sex worker collectives and the Ministry of Health and Family Welfare. The Civil Societies engaged with the Parliamentary Forum on HIV/AIDS and media to stop the Bill from being passed. The proposed amendment was not cleared and lapsed. Section 377 in the Indian Penal Code: Section 377 created obstacles for effective TI implementation for men having sex with men and interfered with fundamental rights of sexual minorities. The reading

down of Section 377 in July 2009 decriminalized consensual sex between adults encouraging the men having sex with men 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 is currently being challenged in the Supreme Court of India. NDPS 1985: Under the Act 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”. At present there is no attempt to review the law either through parliament or through the courts.

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178) **Part B, Section I. HUMAN RIGHTS**

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

Yes (0)

Page 89

179)

Part B, Section I. HUMAN RIGHTS

Question 4 (continued)
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

There is mention of human rights protection 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. GIPA policy guidelines were developed in consultation with various networks and development partners. State level and national level GIPA consultations were held in 2009 for including human rights at the policy level. The GIPA policy is yet to be finalized.

180)

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes (0)

Page 90

181)

Part B, Section I. HUMAN RIGHTS

Question 5 (continued)
IF YES, briefly describe this mechanism:

A mechanism to address stigma and discrimination cases is in place. The Indian Network of People living with HIV/AIDS and the Positive Women's Network periodically conduct public hearings to draw attention to cases of stigma and discrimination. In some states, however, the following initiatives are taken: Goa: Following NACO's call to record instances of PLHIVs facing discrimination in Goa; SACS' mainstreaming consultant undertook the task. Cases were forwarded to NACO. 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 need strengthening. The media has been playing an active part in highlighting cases of discrimination in concert with the networks of people living with HIV and AIDS. The World Bank is supporting selected CSO through a competitive process to implement innovative 18 month projects that reduce Stigma and discrimination. CSO noted their concern that information collected for line listing most at risk populations by NACO may result in discrimination in the absence of a strong mechanism to ensure consent,privacy and confidentiality. Legal Aid services are provided to PLHIV s through CSO like Lawyers Collective and the Human Rights Law Network. In certain states like Tamil Nadu legal aid camps are supported for PLHIV through the SACS.

182)

6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

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183)

Part B, Section I. HUMAN RIGHTS

Question 6 (continued)
IF YES, describe some examples:

People living with HIV and AIDS have actively been involved in the formulation of NACP III and recently the GIPA policy. Draft GIPA policy guidelines have been developed in consultation with various networks and development partners and are likely to be finalized soon. There is opportunity for PLHIV to contribute to state programme implementation as members of the governing body of SACS as well as through appointment as GIPA Coordinators. However one of the challanges has been the absence of any active mechanism to promote GIPA beyond mere tokeneism. There is a general limited awareness amongst civil society on GIPA. The post of 'GIPA Coordinator' remains vacant in several states. Community care centres are managed by the networks of PLHIV and funded by the Government. PLHIV are also involved in the Country Coordinating Mechanism and the Technical Resource Group on IEC. Networks of people who use drugs i.e. the Indian Harm Reduction Network are engaged as members of the Technical Resource Group on IDU in the implementation of the harm reduction component. GFATM provides funding to the Asia Network of Positive People which in turn supports the Indian Network of Positive People.

184)

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

Page 92

185)

Part B, Section I. HUMAN RIGHTS

Question 7 (continued)
IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

The country has the policy of free services in all the three areas. However, there are concerns related to costing guidelines for prevention as a few CSO believe that inadequate budgetary provision has been made in certain areas. Similarly while ART is provided free of cost by the government at the state hospitals, PLHIV in rural areas find it difficult to access services. PLHIV who have to travel to the centre to get ARV would like financial assistance to bear the cost of travel. The management of opportunistic infections is a weak area as it is not provided in the ART centres. Other barriers that hinder access to treatment centres include Location of ART centres in central areas are difficult to access for rural PMTCT programmes need strengthening as access to ante natal care is low. Lack of awareness among women and children about their human rights has also contributed to discrminatory practices like children and women living with HIV and AIDS being denied the right to inherit property. The discriminatory attitude of health care professionals towards HIV positive women is a barrier to obtain medical care—including surgical services. The timings of ART centres are usually from 10:00 am to 5:00 pm, which is the usual working hours for the PLHIV. Alternative timings could help resolve this difficulty. Issues over the insufficient supply of test kits, medicines etc. could be addressed. The eligibility criteria for accessing second line ART, it is recommended, be reviewed. Issues related to limited access of mobile populations particularly, migrants and truckers who need ART needs to be addressed. Although many states have included PLHIV in other social welfare schemes such as free rail passes, etc, participants felt that a separate budget is required for providing financial support to PLHIV.

186)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

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187)

Part B, Section I. HUMAN RIGHTS

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes (0)

188)

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

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189)

Part B, Section I. HUMAN RIGHTS

Question 9 (continued)
IF YES, briefly describe the content of this policy:

The National AIDS Control Prevention Policy 2002 clearly articulates equal access for most at risk and vulnerable populations to prevention, treatment, care and support services. It notes that India has a concentrated epidemic and describes the focus on prevention among these groups in view of the character of the epidemic. However, some groups have expressed their concern regarding the full implementation of the policy.

190)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

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191)

Part B, Section I. HUMAN RIGHTS

Question 9.1 (continued)
IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

The NACP III provides for a minimum package for HRG, specific TI for FSW, IDU and MSM and specific packages for migrants and truckers, and STI clinics in TI.

192)

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

Yes (0)

193)

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

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194)

Part B, Section I. HUMAN RIGHTS

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes (0)

195)

IF YES, describe the approach and effectiveness of this review committee:

NACO has constituted an Ethics Committee to ensure that any research undertaken is afforded serious ethical consideration prior to the commencement of the project and that such a research is consistent with legislative and statutory requirements. As an example, the proposal for the Behavioural Surveillance Survey in Karnataka was channeled through the NACO Ethical Committee. The proposal was approved after revision of proposal text based on the feedback.

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196)

– 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 (0)

197)

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes (0)

198)

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

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199)

Part B, Section I. HUMAN RIGHTS

Question 12 (continued)
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; Law Commission of India and National and State level commissions etc. NACO has established a provision for appointment of an Ombudsman at state level who will monitor instances of discrimination and human rights abuses reported at this level. Anyone facing HIV related discrimination in delivery of health care can approach the ombudsman for speedy redress. A Gender Desk has been set up at NACO to also provide particular attention to women affected and infected by HIV-AIDS.

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200)

Part B, Section I. HUMAN RIGHTS

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes (0)

201)

– Legal aid systems for HIV casework

Yes (0)

202)

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

Yes (0)

203)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes (0)

204)

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

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205)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
IF YES, what types of programmes?

Media	**Yes**
School education	**Yes**
Personalities regularly speaking out	**Yes**
Other: Health care provider training	**Yes**

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206)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

6 (6)

207)

Since 2007, what have been key achievements in this area:

Since 2007 key achievements have been in formulation of the following policies: GIPA policy and the policy on gender mainstreaming. Guidelines and operational plans to mainstream HIV and AIDS for women's empowerment under various other programmes of the Government have been released and are available on the NACO website. The Delhi High Court reading down on Section 377 of the Indian Penal Code is another positive development.

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208)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

4 (4)

209)

Since 2007, what have been key achievements in this area:

To note that the rating was changed at the national consultation in New Delhi. The consultation in Bangalore had provided a lower rating of 3. Since 2007, key achievements in enforcing policies, laws and regulations have been as follows: Collectivisation and Empowerment of Sex Workers, men having sex with men, targeted intervention projects for prevention of HIV on men having sex with men. Allocation of specific funds to address HIV and AIDS associated stigma and discrimination. Increased advocacy with police / armed personnel to mainstream HIV/AIDS. Establishment of district level networks of PLHIV. Stronger role of media to highlight cases of stigma and discrimination against HIV positive people. State specific achievements include the setting up of a trust for orphaned and vulnerable children and establishment of knowledge management centre in Tamil Nadu.

210)

What are remaining challenges in this area:

The existing challenge is that the country needs to work more towards enforcement of existing laws and regulations. Implementation/enforcement of the various policies and programme guidelines need to be strengthened, For example, there is scope to strengthen implementation of operational guidelines for care and support of children. There is a need to address discrepancy between programme and policy guidelines. Stonger implementation of schemes such as the Integrated Child Development Scheme is needed across all states for provision of nutrition to HIV infected and affected children. Discriminatory attitude of health care personnel towards positive women and children. The country has reported cases of positive pregnant women who are denied access to treatment and cases of positive children who are denied admission to school. Setting up of formal structures for reporting and documenting best practices / civil society efforts and stronger mechanism to ensure feedback from civil society to state and national government. Integrating NACP III with the NRHM. Public private partnerships need strengthening. Implementation of the newly formulated GIPA and gender mainstreaming policies. Ratification of the 2005 HIV/AIDS Bill which is pending in the Parliament. Mainstreaming HIV and AIDS services with the existing health care services, particularly at the district level. There continue to be large challenges in implementation across the country. An interesting observation is that the score on this section has been falling since 2005. A possible explanation of this may be the gradual setting up of government structures to take on some of the implementation hitherto carried out through CSO.

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211)

Part B, Section II: CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

3 (3)

212)

Comments and examples:

The most noted contribution of civil society particularly through representation from the men having sex with men community has been the effective advocacy resulting in the reading down of Section 377 of the Indian Penal Code. This has resulted in decriminalization of consensual sex among male adults and hence facilitated the reach and coverage of the HIV prevention programmes. There has been a very strong sex worker movement towards collectivisation in some states, particularly West Bengal, Karnataka and Tamil Nadu. 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. PLHIV have been engaged in strong advocacy for scaling up of the ART programme and, introduction of second line ART. Civil society representatives have also been engaged in the development of Operational Guidelines for Children infected with HIV, Guidelines for implementing Targeted Interventions among injecting drug users and men having sex with men etc. CSO at grass root level have 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. There has been an intensive level of engagement with the development of Guidelines for the NACP III in 2007-08. There is scope for increasing civil society involvement in GIPA operationalisation in HIV/AIDS programme implementation through engagement of PLHIV networks. While there seem to be many examples of CSO involvement, scores have fallen between 2007 and 2009. A likely

explanation may be that the programme has become consolidated with mainstreaming areas becoming more vigorous. Hence CSO participation may have become smaller in proportion. In this section, there was clear disparity between scores given by the South (4/5) and that of North (1/5). One of the possible reasons for this could be the reduced day to day engagement in the NACP III.

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213)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

2. To what extent 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)?

2 (2)

214)

Comments and examples:

There is scope for strengthening Civil Society representatives' involvement in the budgeting process for the NACP III. The few CSO that are invited to certain meetings are not involved in the final decision making process. Representation from national and state level PLHIV networks in budget discussions has been low. Their inputs are not always taken, for example the cost provided to NGO for buying lubricants used for anal sex by men having sex with men is found to be low. Although civil society representatives were involved in developing the National HIV Strategic Plan; their representation was inadequate and not inclusive. Additionally, their inputs or suggestions were not always considered; nor were drafts of the plan forwarded to them for review. As the NACP III is eventually being implemented at the decentralized grass root level, there is a need for higher level of engagement with the civil society. The TI guidelines for budgeting, for example, were centrally developed with poor civil society participation. There is scope for strengthening the information exchange between civil society and the government. CSO are not given accurate reports/data on time. Data thus available with them is either outdated or incomplete. Civil society representation in review of the state programmes is another opportunity for involvement. There is scope for a more robust CSO involvement in the development of the state Annual Action Plans. The score for this section is much lower in 2010 than for 2008 where it was scored as 5/5. The higher rating in 2008 could be possibly due to the initial euphoria of the CSO being extensively engaged in the designing of the NACP-III. This though diminished by 2009. One factor for this was the limited involvement of civil society in the NACP III mid-term review.

Page 105

215)

a. the national AIDS strategy?

3 (3)

216)

b. the national AIDS budget?

2 (2)

217)

c. national AIDS reports?

2 (2)

218)

Comments and examples:

Civil society support on several services for HIV prevention and Care and support has been built into the national AIDS strategy, budget and response. CSO receive funds from the local government for HIV/AIDS prevention, care and treatment interventions outlined in the NACP III. The contribution of CSO is not acknowledged adequately in some instances. A meaningful relationship is yet to evolve between civil society and the government so that the former is considered an asset. The score for CSO have fallen. This could be a perceptional issue. In reality, CSO engagement has been strong in 2008-09 as the programme has consolidated and expanded. However, this could be due to poor information level on this issue among certain sections of CSO.

Page 106

219)

a. developing the national M&E plan?

1 (1)

220)

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

1 (1)

221)

c. M&E efforts at local level?

2 (2)

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222) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

3 (3)

223)

Comments and examples:

Civil society in India consists of NGO, CBO and networks of PLHIV, Faith Based Organisations and female sex worker collectives. CSO implement TI among most at risk populations; and Community Care Centres (Care and Support projects) for people living with HIV. PLHIV networks' representatives are engaged in the governance of the programme such as GIPA coordinators. However there are state level variations in the degree of engagement. Faith based organisations

and female sex worker organisations are engaged in contributing to the national response but have had little success in influencing the programme.

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224)

a. adequate financial support to implement its HIV activities?

2 (2)

225)

b. adequate technical support to implement its HIV activities?

2 (2)

226)

Comments and examples:

NACP III provides for both financial and technical support to CSO and they are able to access support for their HIV activities. However, at the end of the activity period, there is a rush to initiate new programmes and this often results in inadequate planning to prepare and submit new proposals. The total fund allocation is relatively less for the low prevalence states. However the issues faced by women and children affeected by HIV and AIDS in these states require more resource allocation. Adequate financial support is given by SACS to CSO implementing targeted intervention projects but the amount is found insufficient for few costings like travel allowance for outreach workers. This is found to be inadequate as in certain parts of India, particularly the North east, the outreach staff has to be travel long distances to reach the site of the interventions. There are fund disbursement delays in few instances. Technical support is also inadequate. The Technical Support Units set up are more focused on supporting SACS in their administrative functions rather than providing support for CSO to improve the quality of interventions on the ground. Technical Support Units are unable to provide support due to shortage in human resources. Techncial support required specifically for women and children affected by HIV and AIDS needs to be strengthened.There is scope for optimizing technical support provision in Gujarat and Madhya Pradesh. These scores are an improvement relative to what was reported in the 2008 Country Progress Report.

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227)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

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

Prevention for youth	25-50%
Prevention for most-at-risk-populations	
- Injecting drug users	>75%
- Men who have sex with men	>75%
- Sex workers	>75%
Testing and Counselling	<25%
Reduction of Stigma and Discrimination	51-75%
Clinical services (ART/OI)*	<25%

Home-based care	51-75%
Programmes for OVC**	>75%

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228)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

Question 7 (continued)

Overall, how would you rate the efforts to increase civil society participation in 2009?

5 (5)

229)

Since 2007, what have been key achievements in this area:

There has been a significant and sustained increase in participation of CBO, PLHIV networks and representatives from the drug users, female sex worker and men having sex with men community in implementing HIV activities. There are a large number of TI projects commissioned by the government and being implemented by CSO. The Community Care Centres for PLHIV and those who receive ART are often managed on the ground in partnership with networks of PLHIV. CSO representatives are also increasingly invited as resource persons to various training workshops. In addition, community based networks of MSM and sex workers are invited to participate in national consultations. The efforts of civil society (including faith based organizations) are noted in STI service provision, home care and support in the state of Gujarat. There is scope for encouraging a more meaningful participation through taking on board the budget related recommendations of the CSOs.

230)

What are remaining challenges in this area:

There is a need for improved coordination at the state and national levels with the CSO and particularly for greater involvement of PLHIV in all components of the programme. The current level of technical support provided to CSO is inadequate and they are at times viewed as sub-contractors and not as partners. Furthermore, the approach is more towards policing rather than supporting or building capacities of CSO.

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231)

Part B, Section III: PREVENTION

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

Yes (0)

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232)

Part B, Section III: PREVENTION

Question 1 (continued)

IF YES, how were these specific needs determined?

The specific needs for HIV prevention programmes is determined through: Inputs from the ongoing 1,247 TI for HIV prevention among female sex workers, men having sex with men and injecting drug users are provided at the state level through the SACS responsible for implementing the NACP III. The 'link worker scheme' is a short term community based intervention to address the HIV prevention and care needs of the rural community with special focus on high risk populations and other vulnerable groups. Recent mapping of most at risk populations in 18 states and size estimation surveys. Strategic information and evidence generated through operations research. Advocacy on needs and issues of most at risk populations and general population by CSO. Pilot projects, which are later scaled up as interventions across the country is another way of identifying and addressing needs. For example, the STI treatment model, integration of AYUSH with ASHA for strengthening health care delivery etc. are first initiated as pilot projects. The link workers scheme was also introduced through assessment of grass root level requirements. The methodologies of various interventions, however, are developed at the national level. India is a diverse country and there is a need to consider the requirements of specific regions / states of the country. The country has certain structures like the SACS in place for identifying specific needs for HIV prevention programmes. However, there is a gap in understanding specific needs of the youth and migrant populations.

233)

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access

HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Don't agree
Prevention of mother-to-child transmission of HIV	Don't agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Don't agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: Migrants, truckers, street children	Don't agree

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234)

Part B, Section III: PREVENTION

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

5 (5)

235)

Since 2007, what have been key achievements in this area:

To note first that the score for this question has declined vis-a-vis the 2008 Country Progress Report. This may be perceptional issue or related to understanding of the scoring scale. The prevention programme in the country for most at risk populations, migrants and truckers is implemented by CSO and has been scaled up in the past two years. Achievements have been made in the following area: □ Scaling up and increased coverage of the HIV prevention programme. □ Greater community ownership. □ Increased awareness and understanding of the NACP III at various levels. □ Decentralisation of the HIV/AIDS programme at the institutional and structural levels (example, setting up of District AIDS Prevention Control Units). □ Improved condom promotion. □ Mapping and size estimation of most at risk population groups □ Establishment of the link worker programme in high prevalence rural districts for providing HIV services for most at risk populations. □ Expansion of ICTC centres. □ Stronger blood safety programme. □ Re-introduction of the adolescent education programme in certain states and an increase in number of Red Ribbon Clubs set up for young people to increase knowledge and awareness on HIV. □ The world's largest mass mobilisation campaign was launched through the Red Ribbon Express (RRE). The RRE train consists of coaches having exhibition on HIV/AIDS and also attached song and drama troupes for condom demonstration etc has been a major success. □ HIV prevalence rate in Tamil Nadu is on decline. Since 2007, states have progressed in scaling up target interventions and increasing service coverage for most at risk populations. There is scope for further improvement though.

236)

What are remaining challenges in this area:

CSO feel that their involvement is much less in the two years since the NACP III formulation. This may in part be because of the changing nature of the interaction of CSO with the programme. The remaining challenges are: □ Under-performance of PMTCT programme. □ Inadequate stock of insufficient testing kits at ICTC. □ Strengthening of harm reduction programme implementation IDU. □ Expansion of workplace programmes for HIV prevention. □ Timely fund disbursement to CSO for HIV activities. □ Decentralising HIV prevention efforts to state, district and sub-district levels. □ Greater community level participation including by networks for positive people. Other challenges include positive prevention and prevention amongst general population particularly women and children.

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237)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

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238)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1 (continued)
IF YES, how were these specific needs determined?

The specific needs are determined through baseline surveys, operations research and the data collected through interactions at the ART centres. However the needs of PLHAs particularly the pyschosocial support and livelihood issues are not fully addressed. The specific needs for HIV treatment, care and support were determined through a certain—not optimum—level of engagement with the PLHIV networks. It is recommended that there be improvement so that needs of PLHIVs are addressed from the time they are tested until they are eligible for ART. This could be through improvement in the quality of services provided, provision of sexual and reproductive health services for women etc. The second line ARV treatment has limited reach as it is in the early stages of implementation. CSO feel that there is need to review the current drug regimen for second line ARVs.

239)

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

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Don't agree
Sexually transmitted infection management	Don't agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Don't agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Don't agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

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240)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

5 (5)

241)

Since 2007, what have been key achievements in this area:

There is an overall improvement in the score vis-a-vis the 2008 Country Progress Report although the CSO expressed concerns related to service delivery of care, treatment and support services. Since 2007 there has been an increase in the number of Community Care Centres, ART centres, link ART centres and ICTC. Twenty four hour ICTC have also been established. District level networks are playing a greater participatory role. There is improved reporting/data provided for the Computerized Information Management System. The number of ART centres has been scaled up and the implementation of the HIV-TB programme is intensified.

242)

What are remaining challenges in this area:

The main challenges are: Scaling up of ART services and provision of travel support for clients to facilitate access. Managing opportunistic infections within the existing health system. Palliative care under the present Community Care Centre guidelines. Programmes and services for orphaned and vulnerable children need to be strengthened. Treatment for Hep C co-infection needs to be provided by the government. Greater collaboration is required between Government and private sector in Care, support and treatment in order to scale up services for PLHIVs.

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243)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

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

No (0)