Gender and Social Inclusion Strategy/ Indigenous Peoples Framework for the National AIDS Control Support Project (NACSP) 2012-17

National AIDS Control Organization,
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Contents

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APD	Additional Project Director
ART	Anti Retroviral Treatment
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop in Centre
HRG	High Risk Group
HIV	Human Immune Deficiency Virus
ICTC	Integrated Counseling and Testing Centre
IDU	Intravenous Drug Users
JD	Joint Director
MIS	Management Information System
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	Non Governmental Organisation
NRHM	National Rural Health Mission
PLHA	People Living with HIV /AIDS
SACS	State AIDS Control Society
TI	Targeted Interventions
TOR	Terms of Reference
UT	Union Territory

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The Gender and Social Inclusion Strategy/ Indigenous Peoples Frameworkis a document developed in house by NACO with the details on the present interventions and practice to address the issues related to social inclusion and provide the details on the action plan for The World Bank supported National AIDS Control Support Project.

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1. **Introduction and Background**

NACP III (2007-12) has shown considerable gains in halting and reversing the HIV epidemic. The numbers of new annual infections have decreased by 56% over the past decade and the epidemic has begun to stabilize. While there is a clear decline in HIV prevalence, estimates also indicate that the epidemic is concentrated among high risk groups in localized geographical locations. This highlights the importance of understanding infection trends and barriers to access HIV services among different social groups.

The National AIDS Control Organization (NACO) recognizes that larger contextual factors such as poverty, urbanisation, migration and social marginalization have a significant relationship with vulnerability to HIV/AIDS. In addition to this, lack of awareness, education and economic resources also result in creating barriers and limiting the access to HIV/AIDS services particularly for the high risk groups.

The goal of ensuring universal access to HIV /AIDS information and services can only be achieved if the marginalized sections are mainstreamed through appropriate strategies. NACP aims to ensure that the target groups receive services in an equitable manner without any stigma and discrimination through an appropriate Gender and Social Inclusion (GESI) Strategy.

NACO conducted a social assessment focusing on the implementation experience of NACP III (2007-2012) with the objective of assessing the equity, gender and social inclusion aspect of the programme in order to better address the social aspects through a Gender Equity and Social Inclusion (GESI) Strategy for the follow up NACSP funded by the World Bank. This assessment was done on the basis of desk review and field based interactions with the States AIDS Control Societies, policy makers, various development agencies, NGOs, the private sector and other concerned stakeholders. It highlights number of initiatives that NACP III has taken for infected and affected populations.

NACP III launched many key initiatives to increase gender and social inclusion in the national Program. By ensuring that equity and respect for PLHIV formed an important component in both prevention an impact mitigation strategies as guiding principles, added emphasis was provided in addressing this important issue.

1.1Summary of Social Assessment for NACP-IV:

National AIDS Control Organisation (NACO), set up in 1992, is working to slow down the spread of HIV/AIDS infection in the country. The apex body, through the National AIDS Control Programme or NACP, sets out objectives and guiding principles for a phased programmatic intervention. This phase is after completion of the Phase-III of NACP, which has over the years focused on checking the spread of disease, expanded its horizons to include behaviour change, increased decentralization by setting up State AIDS Control Societies

(SACS), NGO involvement, adopting national blood policy and ART treatment for both Adults and Paediatrics. The NACP-1 (1992-1999) was launched in 1992, and later extended from 1997 to 1999, was the first strategic plan for prevention and control of AIDS in the country. It was an effort to develop a national public health programme in HIV/AIDS prevention and control. NACP-II (1999 to 2007) aimed to reduce the spread of HIV infection in India through behaviour change and at the same time increase the ability to respond to the infection. NACP-II, moved away from a programme generating mass awareness on HIV prevention to a programme based on targeted intervention approach. NACP-III (2007-2012) sought to halt and reverse the epidemic by providing an integrated package of services for prevention, care support and treatment. The key thrust areas were: (a) prevention of new infections in high risk groups and general population through saturation of coverage of high risk groups with targeted interventions (TIs), (b) scaled up interventions in the general population, (c) providing greater care, support and treatment to a larger number of people living with HIV/AIDS, (d) strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels, and (e) strategic information management system for monitoring.

1.2. Social Assessment for NACP IV: A Social Assessment for NACP III was undertaken to assess the equity, gender and social inclusion aspect of NACPIII, so as to strengthen the existing programs and to take corrective measures in NACP-IV with special focus, if required. The methodology for the SA involved a review of the NACP documents and NACO publications and activities undertaken by various stakeholders during the period 2007-2012. The process included: (i) Desk Review; (ii) Field based interactions with the States AIDS Control Society; (iii) stakeholder consultations. To understand the perspectives of the key stakeholders, field based interactions with them were conducted.

2. Review of Social Aspects Addressed in NACP-III

NACP- III maintained a thrust on creating an enabling environment so that there is a greater acceptance of infected and affected people by the community. Enabling environment has a ripple effect on prevention, care and support of HIV, and most importantly, when the human rights i.e. to live a life of dignity, without stigma and discrimination are respected, it helps society in many ways. To reduce stigma and discrimination associated with the infected and affected persons and ensure that they have an access to prevention and quality treatment, care, and other supports like legal services, NACP – III took affirmative actions, which were aimed at

- Creating an Enabling Environment
- Addressing Stigma and Discrimination
- Addressing Human Rights, Legal and Ethical Issues
- Addressing the Gender Equality
- Addressing the needs of the Vulnerable and Specific Groups

2.1 Creating an Enabling Environment

NACP III recognized that effective prevention, care,support and treatment for HIV/AIDS is possible in an environment in which human rights are respected and where those infected with or affected by HIV live a life of dignity, without stigma and discrimination. It aimed to work in partnership with PLHA networks and other stakeholders towards creating an enabling environment by addressing issues of stigma, discrimination, legal and ethical concerns. The activities have focussed on creating an enabling environment to address the legal and socio-economic barriers which are likely to adversely impact the outcomes of national HIV response.

Prevention efforts: Targeted interventions are preventive interventions   focussed on high risk groups in a defined geographically areas**.** To create a non-stigmatizing environment and enhance access to services, targeted interventions created mechanisms for advocacy with local government functionaries and key stake holders including PLHIVs. This has brought about changes in the mind-set of marginalised groups and in addressing the stigma related with the high risk groups in health care settings to a large extent, but has facilitated in creating an enabling environment where the High risk groups can avail services. This can be seen from the data which shows increase in the various services like check-up for STI and HIV Testing.

Greater Involvement of PLHIV: As People Living with HIV/AIDS (PLHA) are a critical resource for appropriate and effective response to the epidemic.The programme witnessed a major shift in the role of PLHIV under NACP –II from being mere beneficiaries of services to becoming important partners of NACO, SACS, civil society organizations and service providers. Greater Involvement of People living with AIDS (GIPA) have been facilitated and the role of

PLHIV strengthened by involving them as members of various committees at SACS and NACO. This is done to strengthen the partnership with PLHA networks and other stakeholders towards creating an enabling environment by addressing issues of stigma, discrimination, legal and ethical concerns. Importantly, this facilitated the role of PLHIV as advocates for prevention,care, support and treatment programmes including support services in Drop-in centres. As a result of these initiatives PLHA networks now exist at sub-district, district, state and national levels.

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

- National Council on AIDS (NCA)
- State Councils on AIDS (SCA)
- Technical Resource Groups (TRGs) at national level
- Country Coordination Mechanism (CCM) of Global Fund for AIDS, Tuberculosis & Malaria
- Grievance Redressal Committees at the state level
- NACP IV working groups

They have also been involved in providing services at administrative and service delivery points as:

- GIPA coordinators at SACS
- Care coordinators at ART centres
- Peer educators at Targeted intervention sites
- Peer counsellors, coordinators and out-reach workers at Drop in centers and Community Care centers

Furthermore, PLHIV are involved in training programmes,national and international conferences, advocacy workshops and outreach activities as resource persons/ positive speakers.As partners in the process of mainstreaming, PLHIV and their networks have facilitated leveraging various welfare schemes such as free transport to ART centres, supplementary nutrition, widow pension scheme, legal aid etc. Apart from national level networks, today there are registered networks of PLHIV in almost all states and in about 300 districts. 240 Drop-in-Centres are providing psycho-social support, counselling and referral services and linkages to welfare schemes to PLHIV and are currently functional primarily through these networks. Grievance Redressal Committees have been formed at the State level to address issues of stigma and discrimination against PLHIV particularly in the context of health care settings.

Impact mitigation; Although extending social support for impact mitigation is not the direct mandate of NACO under NACP, in order to extend support to the many PLHIV (over 2 million)

thinly spread across India (0.3% of the adult population), strategic partnerships for mainstreaming of HIV have been established. UNDP is among NACO's main partners in these efforts. NACO has advocated with various Ministries in Central Government and State governments for improving access of PLHIVs, who are also by and large marginalised, to various benefits and services. Efforts have been made to seek support for PLHIV within the existing schemes and by initiating new exclusive schemes for them. Most State AIDS Control Societies (SACS) have a Consultant (Mainstreaming) to work on mainstreaming HIV/AIDS in various programmes of the State governments. As a result, several support schemes for PLHIV have been launched by various Central and State governments.

Sustained and coordinated advocacy efforts at state levels have resulted in major improvement in the provision of social support to the affected people. Fourteen states are providing travel assistance for treatment, 22 states are giving nutritional support, financial support ranging from Rs 200 – Rs 2500 is provided to PLHIVs in 13 states. Besides this, legal aid, crucial to protecting human rights of PLHIVs, is provided in 11 states through different mechanisms such as State Legal AIDS cell, or bar councils. An increasing number of states are provisioning safe shelter for women and children living with HIV.

2.2   Addressing Stigma and Discrimination

NACP-III addressed the issue of stigma and discrimination through communication, research, advocacy, capacity development and partnership building. Stigma and discrimination is an obstacle to an effective response to HIV/AIDS at all levels. Stigma and discrimination is perceived   in social settings including family, community, schools and workplace along with stigma and discrimination from service providers. PLHIV and vulnerable populations themselves are largely unaware of their rights which make the situation worse.

The NACP III guiding principles emphasised the creation of an enabling environment where those infected and affected by HIV could lead a life of dignity. The major initiatives taken during the NACP-III in this regard are as follows:

(i)   Multi-media mass mobilization campaigns such as Red Ribbon Express (RRE) which are involving positive networks for campaign outreach and generating a strong community dialogue on the issue.

(ii)   Spots on radio and TV with messages by celebrities on the issue of stigma and discrimination; special episodes on the issue of stigma in long format radio and TV programmes such as "*Kalyani Health Magazine*" and TV serial "*KyunkiJeenaIssiKaaNaamHai*".

(iii)   Folk media performances in rural areas with focus on stigma and discrimination.

(iv)   Sensitization of medical and para-medical staff on stigma during training programmes; inclusion of stigma and discrimination components within the sensitization programmes

for grassroots workers such as SHG, AWW, ASHA, ANM and members of PRI; advocacy and sensitization programmes for parliamentarians, legislators, faith based leaders, judiciary, police and other stakeholders; media sensitization programmes for journalists on stigma free reporting.

(v)   Involvement of PLHIV as positive speakers at various national and international fora, training programmes and advocacy workshops.

(vi)   Establishing linkages between various service centres and positive networks; setting up of Drop-in-Centres to provide platform for psycho-social support to PLHIV in the districts and to facilitate access to services.

(vii)   Formation of grievance redressal committees in the states to address the issue particularly in medical settings.

(viii) Involvement of PLHIV in various mainstreaming programmes and in leveraging several Government welfare schemes to mitigate the impact of the epidemic on PLHIVs.

(ix)   Establishment of systems to take prompt actions through concerned authorities in case of reports of stigma and discrimination.

2.3   Addressing Human Rights, Legal and Ethical Issues related to health care services

National AIDS Prevention and Control Policy (2002) aims to respect the rights of people living with HIV/AIDS and vulnerable populations. Several policy initiatives have been started during NACP-III to address these concerns and some of which are mentioned below:

- National policy on HIV/ AIDS and the World of Work ensuring non-discriminatory workplace policies and referrals/ linkages to services has been rolled out by the Ministry of Labour & Employment. Several states have conducted State level workshops for dissemination of the policy.
- The operational guidelines for Tribal Action Plan were finalized and shared with key stakeholders. These action plans have been rolled out in 62 A and B category districts across 13 States based on prevalence covering 65 Integrated Tribal Development projects.

During NACPIII advocacy at state level is promoting:

- Better access to health care by PLHIVs.
- Free legal aid in some states for legal issues related to inheritance of property, stigma and discrimination etc.
- Grievance redressal systems at the state levels to advocate and initiate protective action against stigma and discrimination.
- Engagement with insurance development regulatory authority to bring PLHIV within the ambit of health and life insurance products
- Strengthening implementation of the workplace policy

- Addressing the vulnerabilities of migrants through special campaigns
- Review of livelihood schemes and programme to explore livelihood options for PLHIV

2.4 Addressing Gender Equality

The impact of HIV and AIDS reaches far beyond the health sector with severe economic and social consequences. Like other epidemics, it is much more severe on women than men. Biological, socio-cultural and economic factors make women and young girls more vulnerable to HIV and AIDS.

NACP- III has placed reproductive rights of women and adolescent girls high on agenda and this is reflected in the following;
- Equitable access to women and girls in the national HIV response
- Awareness among women and girls to take decisions for prevention of HIV transmission
- Non-judgmental HIV response with a commitment to social inclusion.
- Enable and support women, girls and young people to make informed decisions regarding sexuality and reproductive health
- Promote behaviour change to enable men and women to be safe from HIV and men to be responsible and equal partners in prevention of HIV
- Reduce the prevalent gender related stigma and discrimination especially in the health care settings

Some of the achievements under various components of NACP-III that have addressed gender equality are mentioned below:

(i)   *Prevention:*

- HIV prevalence among FSWs has reduced from about 10% in 2003 to 4.9 % in 2009 with the increase in coverage of TIs reaching 700,000 FSWs out of estimated 868,000 FSWs.
- The Link Workers Scheme (LWS) is reaching out to high risk women population in rural areas including spouses of migrants in 208 vulnerable districts. Approximately half of the link workers are women.
- About 40% of the people reached through the Red Ribbon Express, the worlds' largest mobilisation campaign are women.
- Mass media campaigns in TV and radio supported by mid-media, outdoor and IPC channels continues to focus on women issues. The thematic campaigns on ICTC/PPTCT, condoms, STI, stigma and discrimination, blood safety etc. have been addressing both men and women.

- In 2007 NACO developed a booklet titled "*Gram Sandesh- HIV/ AIDS & the Role of Women Members of Panchayati Raj Institutions*" which was distributed at the gram panchayat level deliberating action from PRIs on issues of women's vulnerability and stigma & discrimination.
- Women PRIs are reached through mainstreaming with the Ministry ofPanchayati Raj through training programmes which incorporated HIV as a component.
- A large number of women SHGs, ANMs, ASHA and AWWs have been trained on HIV/AIDS using a specially designed module- 'Shaping Our Lives' to reach out to rural women & adolescent girls with HIV prevention knowledge, information on care, support, treatment services and on stigma and discrimination issues.

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

- The number of women accessing ICTC/ PPTCT and ART services is steadily increasing.
- Two hundred and forty Drop in Centres (DICs) are operational in the country providing psychosocial support and linkages to services for PLHIV, including women at the district level. There are 6 DICs in the country managed by networks of women living with HIV. About 350 Community Care Centres (CCCs) exist to provide access to necessary care and treatment support. WLHIV are referred from the CCCs to various services centres for further assistance.

(iii) *Stigma, Discrimination & Social Protection:*

Stigma and discrimination has been both a cause and consequence of HIV. NACP III initiated efforts at mainstreaming the response involving other government ministries/ departments in addressing stigma and discrimination. For Social protection of women and children living with and affected by HIV, various social security measures have also been extended. Some key achievements are:
- Financial support provided in some states through the Widow pension scheme
- Positive Women Networks at national/ state / district levels have been encouraged to advocate and promote access and utilization of HIV related services for women.
- Linkages of WLHIV and CLHIV to shelter homes and care homes under M/o Women and Child Development or the M/o Social Justice & Empowerment.

2.5   Addressing the Needs of the Vulnerable and Specific Groups

Apart from women, NACP III considers youth, especially in high prevalence districts, children, including girls in special settings, school drop outs, orphans of HIV/AIDS infected/ affected as vulnerable among the general population. Acknowledging their needs as special, NACP has initiated specific interventions.

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

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

Youth groups are re-categorized into three sub-groups based on their exposure to HIV infection. These are a) Young people in general Population b) Vulnerable young people in high and low vulnerable districts c) Young people most at risk   .
Under NACP-III following efforts were made for prevention of HIV/AIDS among youth.
- Adolescence Education Programme (AEP)
- Red Ribbon Clubs in colleges (RRC)
- Progammes for Out-of-School youth through
  - Link workers
  - *Nehru Yuvak Kendra,* Youth Clubs
  - National Service Scheme (NSS)
- Multi-media campaign focussing on youth in North-Eastern India.
- Targeted intervention

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

2.5.2 Addressing Children (i.e. Below 15 years of age)
It was estimated in 2006 that 50% of HIV-positive children die undiagnosed before the age of 24 months[1]. NACP-III has put in place a policy of providing ART for children through the following and addressed the issues effectively:

- Early diagnosis and treatment for HIV exposed children
- Guidelines on paediatric HIV care for health service providers
- Special training to counsellors for counselling HIV positive children
- Linkages with social sector programmes for accessing social support for infected and affected children through Nutritional, educational, recreational and skill development support
- Establishing minimum standards of care and protection in institutional, foster care and community-based care systems.

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[1] Guidelines on HIV care and Treatment for Infants and Children, 2006

The discussion above indicates that NACP III has played a major role in defining and addressing the issues and gender and social inclusion. However the specific vulnerabilities of certain social groups such as female migrants, wives of migrant workers and female IDUs remain a challenge.

NACP has made more efforts than any other sector to address GESI issues. Having already worked with HRGs, it has created institutional strength to identify, map and reach these groups through a peer led approach. Although there is strong commitment to the GESI agenda and NACP makes it a priority area, the challenge remains in making the initiatives mentioned earlier more sustainable and institutionalized into the structure and implementation process of NACP.

Thus, while recognizing that the high risk, vulnerable and marginalized groups need to be provided services in an equitable manner, it has been deemed necessary to develop a GESI specific strategy. The Gender Equality and Social Inclusion (GESI) strategy would help to reach out to most at risk hidden population.

2.6 No Special vulnerability among Tribal population

The social assessment considered the Tribal Action Plans (TAPs) prepared so far by the states where a significant tribal population exists. In NACP-III, TAPs were prepared and implemented with stakeholder consultations in 62 districts covering 65 ITDA (Integrated Tribal Development Areas) to improve the outreach of information, prevention and comprehensive care and support services for the tribal populations. **A study done in Gujarat indicated the absence of any special vulnerability of the tribal people to HIV infection or incidence thereof on account of their ethnicity.**

2.7. Key Issues and Challenges

NACO has successfully implemented NACP- III and to a very large extent has come very close to its objective of halting and reversing the epidemic. According to recent estimates, the HIV prevalence overall in the country has come down, but new pockets have also emerged posing new issues and challenges. The challenges emerged in the of Coverage, Care and Support, Stigma and Discrimination, and Enabling Environment.

2. 8 Recommendations

Strategies suggested to overcome the challenges include:

• Scaling up and monitoring quality of Coverage of hard to reach MARP
• Strengthening Enabling Environment
• Enhancing access to services for Care, Support and Treatment for MARP
• Strengthening the services under STI Management for MARP
• Increased awareness and widespread communication strategies
• Bringing focus on mainstreaming activities to motivate and empower more MAPRs to avail prevention services.

3. Innovations and Best Practice

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

3.1 Best Practices

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

A few of the Innovations introduced during the program are:

A. **Innovations to scale-up prevention** included: (i) Peer led high risk group (HRG) mapping to enable effective scale-up of targeted interventions (TIs); (ii) link workers scheme as a strategy for reaching high risk and HIV infected and affected populations in rural areas; (iii) involvement of public- private partnership for extension of treatment for sexual transmitted infections (STI), integrated counselling and testing centres (ICTC) and prevention of parent to child transmission (PPTCT) services; (iv) providing opioid substitution therapy for IDUs in public health settings; (v) the nurse practitioner model for providing HIV services to people at primary health services is step towards greater convergence with government health facilities; (vi) master health check-up program in Tamil Nadu linked to existing government services normalised health services for HRGs; and (vii) single prick syphilis/HIV tests. Separate interventions are initiated for TG/Hijra in relevant sites. Migrant intervention strategy is revised based on evidence.

B. **Innovations to strengthen care, support and treatment** for people living with HIV and AIDS (PLWHAs) include: (i) decentralisation of HIV treatment through linked Anti-Retroviral Therapy (ART) centres; (ii) involvement of DAPCU as district level functionary to improve access to government social protection schemes for HRGs and PLWHAs; (iv) exclusion of HIV/AIDS from the exclusion list of RashtriyaSwasthayBimaYojana to bring PLHIV under its cover and (v) the provision of legal aid services in number of the states.. The above innovations allowed NACO to reach out more number of people who need ART and other social entitlements.

C. **Innovations to strengthen the information management system** include: (i) the patient monitoring system; (ii) broad mapping of HRGs; (iii) district epidemiological profiling using data triangulation; and (iv) the use of Strategic Information Management System - a web based reporting system for effective program monitoring. These innovations have raised high performance level of the NACO monitoring and evaluation system, allowing for easy transfer of data and knowledge dissemination. NACO continues to make further improvements in its surveillance methods, including planning for second generation surveillance system: integrated bio behavioral surveillance.

D. **Performance management innovations** include: (i) a web-based computerized financial management system linked with program performance; (ii) TI NGO selection and evaluation procedures that assess NGOs compliance against a standard set of performance criteria, including fiduciary issues, governance, human resource and program performance; (iii) a dash board that provides crucial information for program monitoring, generated from the computerized management information system (CMIS), and (iv) NACO operational guidelines on all major components of the program**.**

4. Consultative Planning of NACP-IV

In order to synthesize evidence, understand what has worked well, what needs to be strengthened and/ or modified from NACP III, and to discuss the emerging / changing nature of the epidemic, NACO planned a series of national and regional consultations with civil societies, development partners, government departments, public and private sector partners, NGOs and networks. The mechanism followed to engage discussions with all the stakeholders included:

- Working Group meetings at the National level
- Regional level
  - o Multi stakeholder Consultation including Civil Society and Community Groups Consultation
- e-consultations

The World Bank supported project called NACSP is part of NACP IV and the components supported by World Bank also part of these consultations. The implementation of NACSP will be within the frame work of NACP IV only.

4.1 Stakeholder Consultations

The planning process adopted for NACP IV was participatory and widely consultative approach similar to that of NACP III and is also further building on the globally acclaimed and successful planning efforts of NACP III. World Bank funded NACSP was also inclusive in NACP IV planning process. The process essentially involved a wide range of consultations with a large number of partners-. Several working groups have been formed and the process essentially involved a wide range of consultations with a large number of stakeholders including

- Parliamentarians
- Government Departments
- NGOs
- Civil Society
- Representatives of PLHAs
- Positive Networks
- Experts in various subjects

The mechanism followed to engage discussions with all the stake holders included:
1. Working Group meetings at the National level
2. Regional level
    I. Multi stakeholder Consultation including Civil Society and Community Groups Consultation
3. e-consultations.

The final blueprint for the NACP-IV was endorsed by the working group of Planning commission as the "final draft of the NACP-IV". The process was spread over 5 months, was participative in nature with large number of participants constituting working groups, regional consultation meetings and e-consultations.

Working Group Meetings: There were about 15 Working Groups with over 20 sub-groups comprising of stakeholders, including more than 250 representatives of Civil Society. These working groups and their sub groups had deliberated on specific thematic areas both at regional and national level. The deliberations of the working groups on the following themes are important from the GESI perspective: Mainstreaming, GIPA, Gender, Stigma, Tis, IEC, Capacity Building, ICTC/PPTCT, Care, Support and treatment, and STI.

Regional Consultative Meetings: In continuation, its policy of wide consultations with all stakeholders at various levels, NACO facilitated 5 regional multi-stakeholder consultations involving key stakeholders from government departments, development partners, public and private sector partners, civil societies, NGOs and community networks from the respective regions. Civil society Organizations, Community Groups and various stakeholders participated in the Regional Multi Stakeholders Consultations.

Regional Multi Stakeholder Consultations: The NACP IV strategy and implementation plan were developed based on the synthesis of evidence through a wide range of consultations with government departments, civil society, public and private sector partners, NGOs, PLHA networks. In order to synthesize evidence, understand what has worked well, what needs to be strengthened and/ or modified from NACP III and to understand the emerging / changing nature of the epidemic, NACO carried out a series of national and regional consultations with civil societies, development partners, government departments, public and private sector partners, NGOs and networks. As part of this process, NACO facilitated 5 regional multi-stakeholder consultations involving key stakeholders from government departments, development partners, public and private sector partners, civil societies, NGOs and community networks from the respective regions.

Region	Total Number of Participants
Bengaluru	69
NewDelhi	106
Kolkata	86
Ahmadabad	96
Guwahati	67
Total	**424**

All the regional multi-stakeholders consultations discussed the thematic areas of working groups on cross- cutting issues. The thematic areas covered included:

1. Overall NACP IV Strategy / Approach

2. Planning and Implementation at State Level including with regard to GESI related cross cutting issues such as: Quality and Access, Integration and Convergence, Leveraging and Partnerships, Gender, and Stigma. These regional consultations fed into the national consultations and provided recommendations for the preparation of NACP IV.

e-Consultations: To include wide range of consultations, NACO initiated e-discussions, titled "**Moving towards NACP-IV - Sustaining and Maximising Results"** which was opened up in June 2011. Based on their experience of working in HIV/AIDS sector, inputs were invited on the following: What worked well under NACP-III, and Why? What needs to be strengthened, and Why? E-discussion was open for two weeks. During the period, the participants gave inputs on areas need to be strengthened.

Working Group on AIDS Control constituted by the Planning Commission: As part of the XII[th]Five Year Plan (2012-17) formulation, the Planning Commission constituted a working group on AIDS Control programme . The draft strategy paper for NACP IV was been prepared after a wide ranging consultation with all stakeholders, including civil society, positive networks, communities, technical experts, and government representatives from state and other central Ministries is termed as "people's program". Encapsulating, NACP-III and earlier phases, the group exults the approach of targeted intervention particularly-which is of great significance for NACSP, among HRG and vulnerable population groups.

The group reiterates commitment to achieving Millennium Development Goals (MDGs). Keeping this in view, The Guiding principles for NACP IV i.e. 2012-2017, of which NACSP is a component will continue to be: Continued emphasis on Three Ones (i.e. One Agreed Action Framework, OneNational HIV/AIDS Coordinating Authority and One Agreed National M&E System), Equity, Gender, Respect for the rights of the PLHA, and civil society representation and participation.

Consultation with Indigenous People: The NACP-III involved preparation of state wise Tribal Action Plans through stakeholder consultations, of which NACSP is a follow up projectunder broad umbrella of NACP with no adverse impacts on the tribal people. The preparation of NACP involved regional consultations in which civil society groups working on HIV related issues and with HRG and disadvantaged people including tribal people took part. During the preparation of the Social Assessment, field visits and consultations were conducted in Andhra Pradesh and Chhatisgarh which have significant tribal populations.

Framework for Consultations during Implementation: The NACO has established robust mechanisms for consultations at the national, state and community levels. At the national and state level stakeholder consultations are held to discuss various aspects of the program on a regular basis, which include matters relating to policies and guidelines, sharing of experiences, review of implementation progress. At the local level this is carried out to raise people's awareness and ensure their participation in the program. The TIs hold regular counselling at the community level to raise awareness and discuss specific issues which is a key aspect of their intervention. This consultative process shall be continued during the NACP implementation.

4.2 Key Gaps and Challenges

As mentioned in the earlier section, significant progress has been made during the NACP III period with regard to gender and social inclusion. There have been a few challenges which need to be addressed to further expand the above interventions. Some of the key challenges are mentioned below.

4.2.1 Risk reduction among high risk groups:

NACP III focussed on saturating the high risk groups (Femalesex workers, IDUs and MSM), and highly vulnerable populations, namely migrants and truckers and the large number of young women and men in the general community with behavior change communication and services. Although significant progress has been made, the desired saturation isyet to be achieved due to various factors mentioned below.

Female sex workers: The present coverage of sex workers through TIs are commendable however due to the changing trend of sex work patterns there continues to be unidentified pockets and also change in the typology of sex work. Though there is a focus on new and young sex workers, it is very difficult to cover 100% of this sub – population.

Men having sex with men: The social assessment acknowledges the efforts of NACO in addressing the issue of MSMs, it states "NACO's HIV programme is the only programme in the country which has shown the courage to respond to the health and development needs of MSM." Despite a very planned and successful intervention, a major barrier is seen in the way to approach outreach services, thereby making reaching to the other typologies of MSM under NACP-III difficult.

Transgender and Hijra: While NACP III had many initiatives with this group, however transgender groups are not homogenous and each section of transgender requires separate attention and services/ activities to address the same. Transgender populations are yet to be mainstreamed through linkages to enable them to access basic social and health related entitlements. The challenge of strengthening the intervention for these groups and empowering them to access the available services needs to be addressed.

Reaching Migrants: Migration has been found to be strongly linked to the HIV epidemic NACP- III reached nearly 2.8 million migrants in the country, through three models of implementation:
- Targeted Interventions, led by NACO and SACS
- Non-TI migrant HIV program led by NGOs partners
- Work Place interventions in organised and unorganized sectors.

NACP-III initially carried interventions with migrants at their destination point, however the revised strategy "National Migrant Strategy and Guidelines (2010)" provides for working with them at Source/place of origin, in transit and at destination points. Working with migrants also required working with spouses of migrants. The spouses of migrants are more vulnerable to HIV due to the risky behaviour of their husbands. However, these spouses of migrants may be based in remote and rural areas, which are currently not identified as high risk areas.

Female migrants: For female migrants working in informal settings, apart from the biological fact that women are more susceptible to HIV, their vulnerability is also related to the work environment, where they may be engaged as domestic help, daily wage labour, etc. Given the unorganised nature of their work, to is difficult to specifically plan action to address their needs.

4.2.2Capacity of Service providers- NACP is working with range of service providers, who may be various backgrounds on contractual basis. High rate of transfers and turnover followed by absence of regular and sustained capacity building framework for service providers creates a gap in building inclusive perspectives. Given the evolving nature of the epidemic and the specialised training required to deal with high risk groups in varied setting , a sustained capacity building process is required .

4.2.3 Working with other Ministries: To address the vulnerabilities of PLHIV and HRGs, there is a need to continue working with others sectors and Ministries. Though there is an on-going effort to work with different ministries, changes in policy and issuing directives is a time taking process. Though NACP has been able to facilitate changes in the existing schemes of other ministries to make it sensitive for PLHIV and HRGs, there is much more to achieve.

5. Gender Equity and Social Inclusion Strategy for the NACSP

5.1 Objectives

The objectives of the GESI strategy are as follows:

- Work towards improving the quality of information and HIV services to various social groups
- Create institutional mechanisms for Gender and social inclusion in the NACP in a sustained manner.
- Prepare actionable guidelines on gender, GIPA, grievance redressal mechanisms to address stigma and discrimination

5.2 Approach

The Gender and Social inclusion approach under NACP would be to consider the vulnerability factors and make effort to address them. Gender and social inclusiveness will be a cross cutting theme in the operational guidelines, training modules, reporting system etc.

It is important to address the healthcare inequalities and related implications among different high risk groups and vulnerable populations due to stigma and discrimination and availability of these services. GESI would provide guidance to service providers to facilitate linkages with appropriate agencies/departments to address the inequities among various groups due to:

- a. Economic reasons (Egpeople living below the Poverty Line i.e BPL category)
- b. Gender reasons (Women& transgender)
- c. Geographical reasons (remote and difficult terrains)
- d. Special vulnerable groups (wives of migrant workers, female migrant workers)
- e. Various high risk groups (FSW, MSM, Transgenders and Hijras and IDU) and bridge populations (migrants and truck drivers)

5.3 Strategies and Plan of Action

The plan of action of the NACP Gender and Social Inclusion strategy proposes to build upon the successes of the NACP III program. As the program evolves, based on newer findings the plan will be flexible enough to accommodate course correction which facilitates optimal implementation of strategies and plan of action. Following strategies have been proposed:

- Creating an enabling environment
- Addressing Stigma and discrimination
- Addressing Human rights, legal and ethical Issues related to health care
- Addressing the gender inequality
- Addressing the needs of the vulnerable and specific groups

A brief summary of the plan of action for each of the strategies is mentioned below:

5. 3.1*Creating an enabling environment*

A supportiveor enabling environment, that address discrimination, socio-cultural inequalities enhances social support for PLHIV and HRGs and promotes greater involvement of PLHIV, is critical to achieving universal access to HIV prevention, treatment, care and support. To achieve this, the following are proposed:

- Continue to Work with Ministries and departments for addressing vulnerabilities and providing social protection
- Strengthen regular feedback mechanisms with related Ministries for monitoring and strengthening GESI
- Advocate for policies, programme and schemes to ensure social protection of PLHIV, FSW, MSM, TG, Hijra and IDU, specially the economically and socially marginalized
- Promote selective convergence with the larger health system to enhancing access to health services for high risk groups and vulnerable groups
- Strengthen initiatives of State Council of AIDS to create policy environment for risk reduction amongst most at risk population and support to PLHIV.
- Law enforcement authorities should be sensitized to deal with PL HIV and High risk groups to reduce harassment

5. 3.2*Addressing Stigma and discrimination*

- Develop strategic framework for addressing stigma and discrimination
- Develop guidelines for Greater involvement of PLHIV
- Continue with the sensitisation of service providers on Gender and Social inclusion to reduce stigma at health care settings
- Sensitise front line health workers (AWWs, ASHAs and ANMs) on gender and social inclusion in HIV/AIDS
- Train mainstreaming officers at SACS for gender and social inclusion in NACP
- The training components under AEP and RRC should reinforce messages against stigma and discrimination
- IEC campaigns and specific messages on reducing stigma and discrimination will be carried out.
- Document and disseminate best practices related to GIPA
- Advocacy with school principals, parent teachers associations, departments of education, NCERT and SCERT, for effective stigma and discrimination measures in educational institutions.

5.3..4Addressing Human rights, legal and ethical Issues related to health care

- Provide training to GIPA coordinators to address Human rights, legal and ethical issues related to health care.

- Facilitate strengthening of Panchayati Raj Institutions to address stigma and legal issues at community level
- Build linkages to Sexual and Reproductive Health services including departments of gynaecology, STI, ANC family welfare, ARSH and post-partum facilities to facilitate right to health for different HRGs and PLHIV
- Facilitate linkages with National legal AID service Authority, State legal AID service Authority, and District legal AID service Authority.

5.3.5.Addressing the gender inequality

- Training and sensitiz**a**tion programmes for frontline workers such as AWW, SHGs and women PRI members
- Promote counselling and testing of pregnant for HIV through the larger health system for prevention of mother to child transmission.
- Access to women controlled methods of prevention such as female condoms by linking TIs and LWS to larger development social marketing programme
- Sensitization and capacity building of DIC staff to address gender issues along with issues related to vulnerabilities and discrimination against WLHIV
- Facilitate capacity building of women and girls to negotiate safer sex through NGO/CBO working on women empowerment
- Clinical services for STIs for MARP to provide treatment of basic health services in order to build the on-going relationship with the service providers and better utilization of services

5.3.6 Addressing the needs of the vulnerable and specific groups

The NACP III considered women, youth, especially in high prevalence districts, children, including girls in special settings, school drop outs and orphans of HIV/AIDS infected/ affected as vulnerable among the general population.

- *Addressing Adolescents and Youth:*

The Adolescence Education Programme (AEP) is designed to provide age appropriate and correct information on the process of growing up, HIV/AIDS, STIs and substance abuse to

reduce the vulnerabilities of adolescents and youth to HIV/AIDS. However , in view of the state specific sensitivities to the content ,few of the states have responded by reformatting the content to position the program as Life skills education, population education and in the Adolescent Reproductive and Sexual Health Programme.

- o Advocacy with Department of Education to promote AEP in states will be undertaken
- o Strengthen the SACS to work with NSS, NCC and NYKs will be strengthened.
- o Efforts will be made to work with the Ministry of Women &Child Development to integrate HIV/AIDS in the SABLA Programme for adolescent girls.
- o Strengthen advocacy efforts with Ministry of Youth and Sports in reaching diverse groups of youth.

- *Addressing Children (i.e. Below 15 years of age):*

About 50-60% of HIV infected children will die by the age of 24 months, if not diagnosed and linked to treatment[2]. To address this issue, efforts are already made in the following areas and will be strengthened further:

- o *Expansion* of Early Infant Diagnosis(EID) to diagnose HIV exposed children at an early stage, where ever possible
- o *Treatment for children found positive through EID*
- o *Build capacity for implementation of Guidelines on paediatric HIV care for health service providers, through paediatric centres of excellence.*
- o *Special training to counsellors for counselling positive children, specially on issues of disclosure of status and adolescent counselling*
- o *Special training to counsellors for counselling of parents of HIV positive children;*
- o *Linkages with social sector programmes for accessing social support for infected and affected* children

As and when necessary, depending on the evolving scenario during the NACP, interventions will be made to ensure the robust and efficient implementation of the GESI strategy.

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[2] Guidelines on HIV care and Treatment for Infants and Children,2006

6. Indigenous Peoples Framework

This section summarizes: (a) information regarding the Tribal Action Plan implemented in NACP-III provided in the Social Assessment, (b) Approach to IPs adopted for NACSP in view of its focus on high risk and hard to reach marginalized groups irrespective of social background and limited impacts on tribal populations, (c) key measures in compliance with Bank OP 4.10.

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

- Strengthening AIDS prevention and treatment services in the predominantly tribal north-eastern region.
- Collaborate with officials of the Integrated Tribal Development Authorities (ITDAs) to improve prevention and treatment services in states with designated tribal sub-plan areas which have concentrated tribal populations. Where everneeded, IEC materials will be translated in local dialect and local communication channels used to promote safe behaviour, increase access to condoms, and provide referrals to ICTC and ART services. These services are provided free of charge to poor tribal people. Patients and attendants who travel to health centres for diagnostic or treatment services are supported for travel expenses.
- Tribal people who are dispersed among non-tribal populations are reached through mainstreaming efforts, particularly IEC, interventions for migrant workers, and other local initiatives.

In all three situations, NGOs/CBOs (especially but not only those involved in tribal development activities, such as residential schools and producer cooperatives) will collaborate in prevention and referral activities, and those with hospitals and mobile dispensaries will also support treatment and care. Within all three situations, districts in the High and Moderate Prevalence categories will be given priority attention.

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

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

i.   Assessment of HIV/AIDS vulnerability factors and availability of HIV services.
ii.   Based on aforesaid assessment, formulation of Action Plan and identification of NACP – III norms/guidelines needing relaxation for more appropriate response.
iii. Implementation of services or activities for addressing specific needs of tribal areas/communities
iv.   Mainstream HIV/AIDS activities in the schemes/programs/structures targeted at the tribals& build their capacities to do so on a sustainable basis
v.   Strengthening linkages among the Tribal, Health & HIV/AIDS sectors for a more sustained response to HIV/AIDS

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

The Tribal Action Plan was rolled out in all 65 ITDP areas in 62 'A' and 'B' category districts across thirteen states — Andhra Pradesh, Gujarat, Tamil Nadu, West Bengal, Karnataka, Chhattisgarh, Orissa, Rajasthan, Manipur, Assam, Madhya Pradesh, Maharashtra and Tripura . State level workshop for joint planning and sensitisation   between Department of tribal affairs and SACS as well as Training of trainers to create a pool for capacity building of all personnel involved in tribal development has been done in most of the states.

The TAPs focused on measures such as: stakeholder consultations to discuss and prepare Action Plans; advocacy to sensitize government officials in charge of Tribal Welfare, training for folk performers on HIV / AIDS, street theatre performances, training of trainers (ToT) program for master trainers from tribal districts, mobile out-reach teams, ToT for tribal welfare and PRI functionaries in tribal areas, etc.
NACP is evidence led intervention and future actions to address the vulnerability of tribal population will be based on the vulnerability study conducted in Gujarat, which shows there is no special vulnerability for tribals for HIV.

6.2 NACSP Approach to Tribal Population:The social issues relevant to Targeted Interventions, , include (i) stigma and discrimination, (ii) gender issues related to gender minorities and women, (iii) outreach to high risk groups and the bridge populations, (iv) (vi) culturally sensitive and need-based IEC for different groups, and (v) establishing necessary linkages with other schemes to enhance the quality of outcomes. These issues are addressed by

NACP, including the behaviour change communications which focus on stigma reduction and the TIs which specifically target vulnerable groups. The national program addresses social protection issues of people living with HIV/AIDS through mainstreaming linkages with concerned Ministries. Two important structural interventions added to NACP-III, which will be continued in NACP IV are: strengthening enabling environment for TIs, and community ownership building.

The NACSP will thus benefit all vulnerable and disadvantaged communities at risk including the tribal population groups based on evidence. The Social Assessment has not indicated any adverse impacts likely to affect the indigenous people, and therefore implications for tribal people under this Project will be based on the vulnerability factors rather than ethinicy.

Under the Bank-funded NACSP, the specific focus of TIs will be on most at risk population including hard-to-reach and other vulnerable populations, wherever they are identified irrespective of their ethnic status through inclusive and non-discriminatory coverage based on evidence. A HIV vulnerability assessment piloted in Gujarat under NACP-III ruled out any statistically significant correlation of HIV prevalence with geographical location, social system, or ethnic identity of tribal people living in pockets of the state. The study emphasized the need for appropriate IEC and other support measures for HIV prevention amongst the tribal people in view of their low awareness levels, poor health seeking behaviour, and weak socio-economic conditions. NACP focus on the indigenous people will on awareness about HIV, access to services, utilization of services.

6.3 Measures to Benefit Disadvantaged Tribal Populations

   I. **The IEC strategy**, which emphasizes use of culturally appropriate media and outreach, will be customized to address the tribal people's information and education needs.

  II. **Mid media :** Folk media is a powerful medium of communication to disseminate difficult social messages in rural areas. Integration of messages with local culture helps rural people to relate and respond easily. NACO has been conducting "*ZindagiZindabaad*" campaign using folk troupes for information dissemination at village level. To strengthen the folk media component, NACO continues the practice of conducting national workshops before rolling out the campaign. The National Folk campaign in its first phase covered tribal districts on a priority basis; in Tamil Nadu, Karnataka, Maharashtra, Gujarat, and Odisha over 2000 folk performances were conducted in 23 tribal districts. A total of 10,692 performances were done across 18 states covering 2.8 million people. The key messages included safe sex, migration, stigma & discrimination, counselling & testing, PPTCT & women issues, blood safety and vulnerability of youth. This process shall be continued.

 III. **Multi-media Campaign:** State AIDS control Societies are carrying forward the NACO initiated special multi-media campaigns in all North-eastern states to increase awareness, educate youth on HIV/ AIDS issues and to promote safe behavioural practices. During the campaign, the HIV/ AIDS messages are disseminated through a series of music and sports events in view of popularity of music and sports among the youth of the North-

East. To maximize the engagement of communities, a calendar of events and traditional festivals was developed for each state, and IEC activities based on this calendar were undertaken throughout the year. Special eff ort is made to reach out to the out of school youth in the states through youth clubs at district, block and village levels. This process shall be carried forward with special focus on tribal predominant states.

IV. **Service delivery:** The health infrastructure and manpower provisions in the tribal predominant states emphasize an inclusive outreach strategy. The number of Sub-centres, PHCs and CHCs established in hilly and tribal areas is higher than in the plains. As per the government of India norms, a Sub-centre is established for a population of 3000 in the hilly / tribal areas as against a population norm of 5000 per Sub-centre in the plains, which reflects the GoI's commitment to improving tribal people's access to the health services. Similarly, a PHC is established for 20,000 people and a CHC for 80,000 people in hilly and tribal areas compared to 30,000 (for PHC) and 1, 20,000 (for CHC) in the plains respectively. Mobile check-up and IEC vans for enhancing outreach and assistance for enabling better access to services, adopted by some states, will be encouraged. ( )

V. **Training of Frontline Workers**: As a part of the strategy to enhance multi-stakeholder involvement at grassroots level; trainings with information of HIV prevention, treatment, care & support are prioritized by NACO. About 5.61 lakh frontline workers (AWW, ANM, ASHA), SHG workers, PRI members and personnel from various government departments, representatives of civil society organization and member of public and privates sectors have been trained through State AIDS Control Societies. This will be continued with priority in tribal districts.

VI. **Counselling** with social and cultural sensitivity is emphasized at the level of TIs and ICTCs/PPTCTs where HRG people are referred to for testing through special training. The issue of case load on counsellors is being addressed by monitoring demand, which will be continued. Specialized training for counselling on issues like stigma, rehabilitation, disclosure to children and youth will be emphasized.

VII. **Capacity Building** for TIs is being carried out by State Training & Resource Centres (STRCs), designed to provide training and develop the capacity of TI projects staff to ensure the quality of interventions. The 17 STRCs established so far work closely with the State AIDS Control Societies and TSUs to build the capacity of TI staff based on training needs assessment. The training covers outreach workers, peer educators and clinical staff (doctors and nurses), and counsellors in TIs. . This training will include modules to understand and address the needs of the tribal populations with regard to NACSP.

VIII. Migrant health and communication campaign- Since migration has been identified as one of the vulnerability factors for Tribal population, special migrant health camps are being organised to reach migrants and their spouses under Migrant intervention strategy.

7. Grievance Redress Mechanism

The National AIDS Control Organization, Department of AIDS Control, Ministry of Health and Family Welfare (MoHFW) has successfully implemented a Governance and Accountability Plan (GAAP) for the Third National AIDS Control Program (2007- 2012). The actions taken included:

- improvement in quality assurance mechanisms through mandatory certification schemes and post-delivery testing of drugs and kits during entire life in addition to mandatory pre-delivery inspection and testing;
- improving bidding process and mitigating collusion through checking the authenticity of the experience certificates, manufacturer authorization, bid security etc;
- improving competition through evolving generic and broad technical specifications and past using those specifications in the schedule of requirement;
- strengthening procurement implementation and contract monitoring through use of data of market survey of manufacturers and suppliers of health sector goods (with its continuous updates) while framing qualification criteria and preparation of Annual Procurement Plans by SIAs.
- strengthening inventory management system by increasing oversight on decentralized management of storage and distribution of drugs and kits.
- disclosing information by posting annual procurement plans, technical specifications, bidding documents and request for proposals on the NACO website;
- improving program management using a dashboard at national and state levels to effectively monitor program performance, and
- developing the computerized financial management system.

State Grievance Redressal Committee (SGRC): At the state level, Grievance Redressal Committee has been constituted to review the functioning of the ART Centres. The Committee is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director of Health Services, and the Nodal Officers of the ART Centres, representatives of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances on PLHIV are brought into notice of state authorities and SACS in a systematic manner for their timely response. So far, 106 meetings had been conducted in various states and over 500 cases taken up and necessary directives have been issued.

GIPA: NACO has prepared the Draft National GIPA Guidelines in consultation with partners and representatives of various networks, working in the area of HIV. 8 Regional and 1 National level consultations were organized to ensure wider participation and inclusion of concerns of PLHIV and networks at the state and the district level. The GIPA Policy is now being put up on the website of the National AIDS Control organization for comments and inputs of partners in the field of HIV.

RTI capacity: NACO has appointed the Central Public Information Officer (CPIO) and Appellate Authority (AA) under RTI Act -2005 for NACO

(http://nacoonline.org/upload/Right%20To%20Information/office%20order%20reg%20CPIO%202.pdf). Three senior officers identified as CPIO and 7 AA to address the RTI issues for various components (AA officers in charge for designated components). Similarly, the SACS have one designated officer as PIO who address the RTI issues in the prescribed timeline. NACO have system of transparency related to the RTI application and the response disclosed in the web site

([http://nacoonline.org/upload/Right%20To%20Information/Status%20of%20RTI%20Application%20April%202011[1].pdf](http://nacoonline.org/upload/Right%20To%20Information/Status%20of%20RTI%20Application%20April%202011[1].pdf)). The system of transparency vary across states.

Public Grievance: NACO has the provision of addressing the grievances which register the issues online through their website. The website get connected to the portal of The **Department of Administrative Reforms And Public Grievances** which is the nodal agency to formulate policy guidelines for citizen-centric governance in the country. Redress of citizens' grievances , being one of the most important initiatives of the department, DAR&PG formulates public grievance redress mechanisms for effective and timely redress / settlement of citizens' grievances.

8. Resources

NACO already has systems in place that address the issues related to gender and inclusion. The majority of the issues are addressed through the activities of mainstreaming. The costs towards implementing the GESI shall be met from the implementation support budget for NACP IV and that GESI activities will be implemented as a cross cutting part of all programme activitiesof NACO.

9. Monitoring, Reporting and Evaluation

NACO has developed a very strong and robust monitoring and evaluation system, including a computerized management information system (CMIS) which has been incorporated into a web-based Strategic Information Management System (SIMS) that is being rolled out across the country. These systems generate information from the SACS on key performance indicators that help NACO to track program performance. The core performance management data are included in a national "dash board", to be updated for NACSP and continue to serve as a management tool for SACS, NACO and its development partners. The SIMS will enable individual level data collection for key program areas and has built-in real-time analytical, triangulation and data validation capabilities, to be fully optimized during NACSP. There will not be any separate system for monitoring and reporting GESI. The established M&E system will be used to monitor the implementation of GESI and IPF through the existing review systems of NACO.The best practices, lessons learnt and innovations which promote Gender and Social inclusion will be documented .

NACO has prepared a NACP IV results framework, to support NACP objectives, with performance indicators and targets. The IBBS will complement the current annual HIV sentinel surveillance system that generates data on HIV prevalence among HRG.

Under NACP-IV, it is envisaged to have an overarching Knowledge Management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use. This will encompass knowledge creation, collection and archiving, sharing and translation.

The strategy will ensure:

- high quality of data generation systems such as Surveillance, Programme Monitoring and Research;
- strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms;
- emphasis on Knowledge Translation as an important element of policy making and programme management at all levels; and
- Establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme.

The element of Knowledge Translation will be given the highest priority to ensure making the link between Knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of epidemiologists, M&E officers and statisticians as well as programme managers in appropriate and simple methods and tools of analysis and modelling.

NACP-IV will continue to document, manage and disseminate evidence for effective utilization of programmatic and research data.

The surveillance systems will be further strengthened with focus on real time monitoring, in-depth epidemiological investigations on the emerging epidemics. National Integrated Biological and Behavioural Surveillance (IBBS) among High Risk Groups will be launched in phased manner to generate bio-behavioural estimates at district level. Triangulation approaches will be refined and adopted to make the best use of epidemiological information from programme sources such as PPTCT, TI and ART, to further corroborate the findings from surveillance.

Research priorities will be customized to the emerging needs of the programme. Emphasis will be given to undertaking HIV/AIDS research required to answer the key questions and grey areas in the programme. Mechanisms for promoting research studies, processing research proposals for technical and ethical clearances and monitoring of commissioned studies will be further strengthened.

Strategies and systems for concurrent, mid-term and end-term evaluation of various interventions will be built into the programme, so that timely assessments can be undertaken in a robust and easy manner. These evaluations shall focus on all components such as process evaluation, outcome and impact evaluation, cost-benefit and cost-effectiveness analysis and other relevant modeling approaches.

10. Definitions (World Bank Sectoral Analysis Sourcebook)

Gender Equality: Gender equality is concerned with the socially constructed differences between women and men (usually inequitable), and believes that in order to gain equitable outcomes, different methods and approaches have to be adopted.

Social Inclusion: Social inclusion is defined as the removal of institutional barriers and the enhancement of incentives to increase access of diverse individuals and groups to development opportunities. In the context of NACP it means equal and equitable access to basic HIV/AIDS service for prevention, care, support and treatment.

Empowerment: Empowerment means building the capacity of the marginalized groups to access services
Social Exclusion: Social exclusion comes from the existing social practices, beliefs, values and norms which puts the marginalized groups outside mainstream development and are excluded from its gains.

Equality: Equality means having no differences in facility, respect and rights. Gender and social (caste/ethnicity) equality is to recognize biological and societal differences and bring changes to the social values, norms, perspectives, thinking and beliefs such that women and men, and higher and lower castes maintain equal status.

Equity: Equity is the state or quality of neutral, fair and just behaviour. It is helpful to consider inequity: differences which are unnecessary and avoidable; and considered to be unfair and unjust. Equality cannot be gained through merely providing equal opportunities, as not everyone is able to access the opportunity equally.

Gender discrimination: Gender discrimination is the relationship between women and men and the culturally and socially established difference in the roles that they play and the subsequent inequality. The difference between men and women is constructed by the society and changes with time; it differs according to place, context, cultures of castes and ethnic groups. In many societies women are treated as subordinates (second class citizens). This has affected women's ability to exercise their rights to services; there is even a situational denial of their right to access information, adequate nutrition, health services, education, access and control over finances and property, their reproductive rights, family planning, etc.

Indigenous people ; There is no widely accepted definition of indigenous peoples. The World Bank's official position is that "because of the varied and changing contexts in which Indigenous Peoples live and because there is no universally accepted definition of Indigenous Peoples, Indigenous Peoples may be referred to in different countries by such terms as 'indigenous ethnic minorities,' 'aboriginals,' 'hill tribes,' 'minority nationalities,' 'scheduled tribes,' or 'tribal groups' (Operational Directive 4.10)[3]." For the countries studied in Asia and Africa, it uses terminology and population breakdowns typical in those countries. Thus, in China, Lao People's Democratic Republic, and Vietnam, it uses "ethnic minority"; in India, "Scheduled Tribes".

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[3]OP 4.10 "contributes to the Bank's mission of poverty reduction and sustainable development by ensuring that the development process fully respects the dignity, human rights, economies and cultures of indigenous peoples." Policy brief of The world bank on indigenous people (Draft World Bank Operational Policy 4.10)