

MAINSTREAMING & PARTNERSHIPS

A Multi-sectoral approach to
strengthen HIV/AIDS response in India



National AIDS Control Organisation

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



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Resilient nations.*

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Preface

The first case of AIDS was identified in 1986 and the Government of India responded promptly to prevent the spread of the epidemic in the country. The National AIDS Control Programme was initiated in 1992 and has completed three phases of implementation. The programme has to a large extent succeeded in halting and reversing the epidemic, but the momentum needs to continue to reach the goal of zero new infections, zero AIDS related deaths and zero stigma and discrimination.

The National AIDS Control Programme of GoI is acclaimed to be a global success in terms of achieving the reversal of the HIV epidemic in the country. The adult HIV prevalence at national level has continued its steady decline from an estimated level of 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011. As per current estimates, there are 2.1 million persons infected with HIV (HSS 2011).

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the last decade from 2.74 lakh in 2000 to 1.16 lakh in 2011. This is one of the most important evidence for the impact of various interventions under National AIDS Control Programme and scaled-up prevention strategies.

Moving forward, to reach the last mile of success, much more still needs to be done. The scale of the response for both prevention and care is huge in the country. Several challenges and gaps continue to exist as an impediment to responding effectively to the HIV epidemic.

There is a need to improve the scale and coverage for risk reduction. While there has been a great progress in terms of improved treatment access for PLHIV, there is an increasing need for impact mitigation. This can only be achieved through improved access to sustainable livelihood opportunities, reduction in stigma, and access to legal and social protection for the infected and affected population.

Every individual infected or affected by HIV in the country needs to be reassured of a life of dignity and well being. This calls for a multi-sectoral response in the country that ensures participation of all the relevant sectors in the fight against the disease.

Concrete action towards multi-sectoral collaboration in the fight against HIV was initiated in the country in 2005, when the Government of India constituted the National Council on AIDS (NCA) with the Honorable Prime Minister Shri Manmohan Singh as the Chairperson. NCA demonstrated the highest level of commitment in the country to provide policy directions, programme framework and to mainstream HIV/AIDS issues in all ministries as well as to forge partnerships with private sector organisations, donor agencies and civil society.

Since then, several steps have been taken in the country for a multi-sectoral response to HIV and AIDS. Different ministries, private sector as well as the civil society have actively participated in responding to prevention and care needs of those infected and affected by HIV. This monograph is an attempt to consolidate these varied experiences and lessons in mainstreaming HIV and AIDS within various ministries and sectors. Besides, this document is a restatement of commitment to the multi-sectoral collaboration. It seeks to provide a road map for a concerted and concrete effort towards a comprehensive response to HIV and AIDS in the country.

The mainstreaming and partnerships framework laid out in this document focuses on efforts at risk reduction, improved access to prevention and care services, access to social protection and ensuring a stigma-free environment for those infected and affected by the disease.

We hope that this publication will guide and motivate the future efforts of mainstreaming HIV in the country and facilitate multi-sectoral collaboration in reducing vulnerability and also in scaling up interventions for impact mitigation of infected and affected people including most at risk population. We believe that every concerned Ministry/department and sector can play a vital role in contributing towards the agenda of *halting and reversing the epidemic* in the country.

Lov Verma (IAS)
Secretary,
Department of AIDS Control
Government of India

Message

The response to HIV in India has evolved considerably since the first few cases were reported on the continent in the early 1980s. After the initial medical and public health responses through the 1990s, there was an enormous expansion in the scope of the strategic approaches and level of political and financial commitment to fight the disease.

In the absence of a vaccine or cure, the response expanded far beyond the traditional confines of the health sector. Perceiving strong links between HIV and the greater development processes, the Department of AIDS Control, in partnership with UNDP and other development partners has reached out to a wide array of stakeholders to implement a broad multi-sectoral agenda. This expansion in vision was accompanied by a corresponding development of institutional structures and coordination mechanisms.

The multi-sectoral response to HIV/AIDS in India has been guided by the National AIDS Control Programme, Phase 3 (NACP 3) Strategic Plan. This monograph covers this very trajectory of the mainstreaming, integration and social protection response. It also captures that the myriads of multi-sectoral approach has moved beyond rhetoric into national and donor strategies. This document is aimed at any person or programme interested in mitigating the spread of HIV, though the emphasis is on those who are in India, and are seeking new ways to act. We hope that the ideas shared in these pages will resonate and stimulate you to adapt them to meet your needs and your situations.

We would also like to reiterate that the partnership between UNDP and Department of AIDS Control is of special nature and builds on many years of trust and mutual commitment. This indeed inspires us going forward, that we shall succeed through our continued collaboration in the achievement of the Country Programme's ambitious targets and contribute to the national development outcomes.

Lise Grande
UN Resident Coordinator and
UNDP Resident Representative

Abbreviations

AAV	Antyodaya Anna Yojana	HAART	Highly Active Antiretroviral Therapy
AFMC	Armed Forces Medical College	HIV	Human Immunodeficiency Virus
AFMS	Armed Forces Medical Services	HRG	High Risk Group
AIDS	Acquired Immune Deficiency Syndrome	HSS	HIV Sentinel Surveillance
ANC	Antenatal Care	ICMR	Indian Council of Medical Research
ANM	Auxiliary Nurse Midwife	ICPS	Integrated Child Protection Scheme
ARSH	Adolescent Reproductive and Sexual Health	ICTC	Integrated Counselling and Testing Centre
ART	Anti Retroviral Treatment	IDA	International Development Association
ASHA	Accredited Social Health Activist	IDU	Injecting Drug Users
ASSOCHAM	Associated Chambers of Commerce and Industry in India	IEC	Information, Education and Communication
BCC	Behaviour Change Communication	IFC	International Finance Corporation
BSNL	Bharat Sanchar Nigam Limited	IHM	Institutes of Hotel Management
BSS	Behaviour Surveillance Survey	IITM	Indian Institute of Tourism and Travel Management
CAPF	Central Armed Police Force	ILO	International Labour Organization
CBO	Community-based Organisation	IRCA	Integrated Rehabilitation Centre for Addicts
CCC	Community Care Centre	ISO	International Organization for Standardization
CD4	Cluster of Differentiation 4	IT	Information Technology
C-DAC	Centre for Development of Advanced Computing	ITDA	Integrated Tribal Development Agency
C-DOT	Centre for Development of Telematics	ITDC	India Tourism Development Corporation
CDPO	Child Development Project Officer	ITDP	Integrated Tribal Development Programme
CEO	Chief Executive Officer	ITI	Information Technology Institute
CII	Confederation of Indian Industry	LAC	Link ART Centre
CIL	Coal India Limited	LFA	Legislative Forums on HIV and AIDS
COE	Centres of Excellence	LWS	Link Worker Scheme
CSC	Common Services Centre	MARP	Most-at-Risk Population
DAPCU	District AIDS Prevention and Control Unit	MHA	Ministry of Home Affairs
DCD	Development of Communication Division	MHRD	Ministry of Human Resource Development
DGAFMS	Director General Armed Forces Medical Services	MIB	Ministry of Information and Broadcasting
DRDA	District Rural Development Agency	MNC	Multinational Corporation
DRDO	Defence Research and Development Organisation	MO	Medical Officer
EID	Early Infant Diagnosis	MoHFW	Ministry of Health and Family Welfare
EQAS	External Quality Assessment Scheme	MoLE	Ministry of Labour and Employment
FBO	Faith-based Organisation	MoLJ	Ministry of Law and Justice
FICCI	Federation of Indian Chambers of Commerce and industry	MoDNER	Ministry of Development of North East Region
FSW	Female Sex Workers	MoRD	Ministry of Rural Development
GDP	Gross Domestic Product		
GIPA	Greater Involvement of People with HIV/AIDS		

MoSJE	Ministry of Social Justice and Empowerment	PIL	Public Interest Litigation
MoU	Memorandum of Understanding	PIP	Project Implementation Plan
MSM	Men who have Sex with Men	PLHA	People Living with HIV/AIDS
MTNL	Mahanagar Telephone Nigam Limited	PLHIV	People Living with HIV
NABL	National Accreditation Board for Laboratories	PPTCT	Prevention of Parent to Child Transmission
NACB	National AIDS Control Board	PRI	Panchayati Raj Institution
NACO	National AIDS Control Organisation	PSU	Public Sector Undertakings
NACP	National AIDS Control Programme	RCH	Reproductive Child Health
NAEP	National Adolescent Education Programme	RDK	Rapid Diagnostic Kit
NALSA	National Legal Services Authority	ROSA	Regional Office for Southern Africa
NCA	National Council on AIDS	RRE	Red Ribbon Express
NCEAR	National Council for Applied Economic Research	RTI	Reproductive Tract Infections
NCERT	National Council of Educational Research and Training	SAIL	Steel Authority of India Limited
NCHMCT	National Council for Hotel Management and Catering Technology	SATCOM	Satellite Communication
NeGD	National e-Governance Division	SCA	State Council on AIDS
NERO	North-East Regional Office	SHG	Self Help Group
NGO	Non-governmental Organisation	SIRD	State Institutes of Rural Development
NIC	National Informatics Centre	SME	Small and Medium-Sized Enterprise
NIIHAR	Network of Indian Institutions for HIV/AIDS Research	ST	Scheduled Tribe
NIPCCD	National Institute of Public Cooperation and Child Development	STI	Sexually Transmitted Infections
NREGA	National Rural Employment Guarantee Act	STQC	Standardisation Testing and Quality Certification
NRHM	National Rural Health Mission	STRC	State Training Resource Centre
NSEP	Needle-Syringe Exchange Programme	SWAp	Sector-Wide Approach
NSS	National Service Scheme	TAP	Tribal Action Plan
NSSO	National Sample Survey Organisation	TDD	Tribal Development Department
NYK	Nehru Yuva Kendra	TI	Targeted Interventions
NYKS	Nehru Yuva Kendra Sangathan	TNSACS	Tamil Nadu State AIDS Control Society
OST	Opioid Substitution Therapy	TNSLSA	Tamil Nadu State Legal Services Authority
		TSU	Technical Support Unit
		UNDP	United Nations Development Programme
		UNGASS	United Nations General Assembly Special Session
		UNODC	United Nations Office on Drugs and Crime



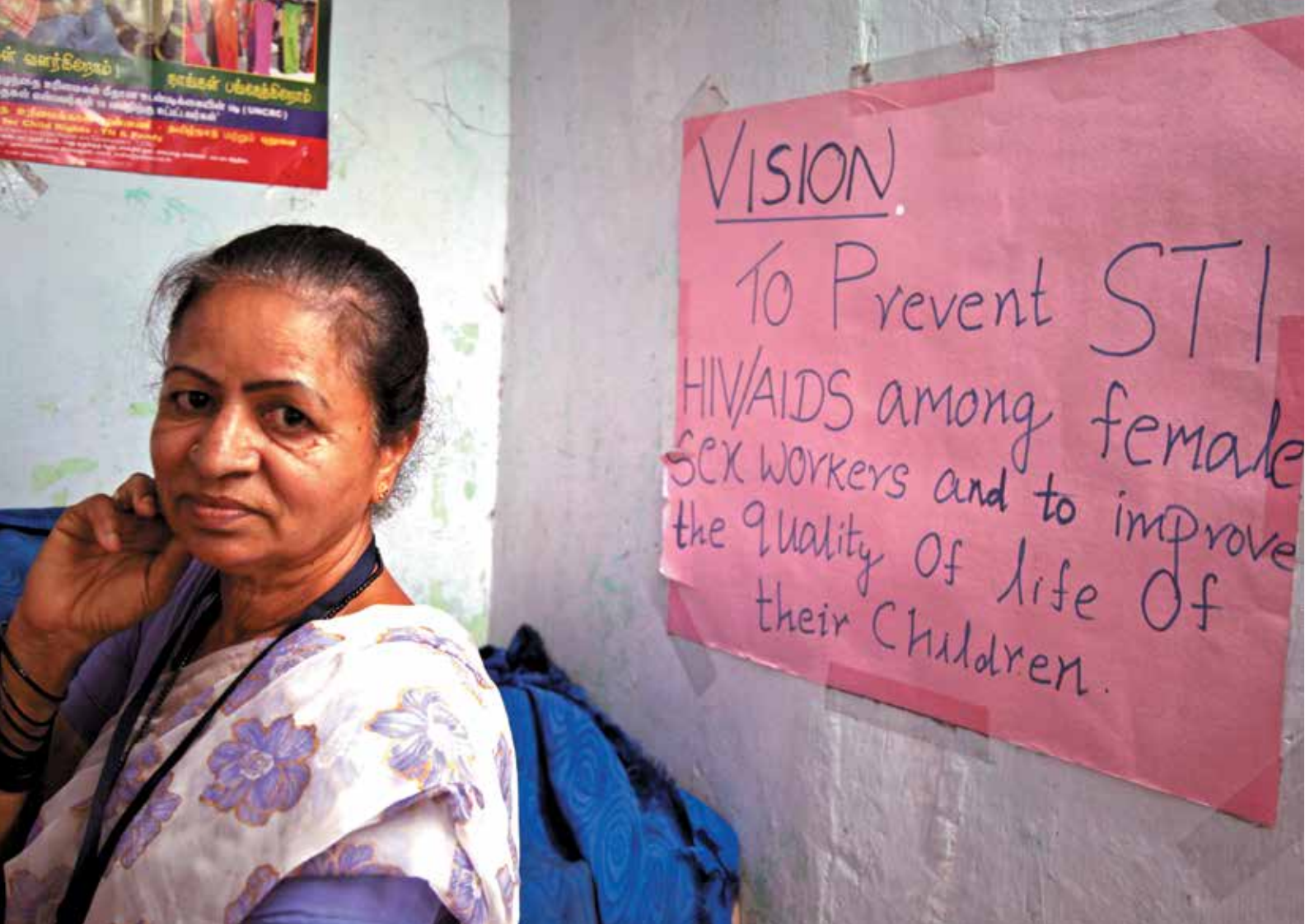
I. Introduction

The total number of PLHIV – people living with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) – in India is estimated at around 20.9 lakh in 2011. Children less than 15 years of age account for 7 per cent (1.45 lakh) of all infections; 86 per cent are in the age group of 15–49 years. Of all HIV infections, 39 per cent (8.16 lakh) are among women. The epidemic is concentrated in high-risk populations such as sex workers, men who have sex with men (MSM), transgender people, injecting drug users (IDUs) and clients of sex workers.

What sets HIV apart as a growing concern is its psychological and economic impact on persons infected and affected by it. The economic and social impact of HIV is not uniform yet, wherever it strikes, it affects individuals, communities and sectors, relentlessly eroding human capacity, productivity and prospects.

The 2011 Political Declaration on HIV and AIDS, adopted at the UN General Assembly advocates for national bodies to engage in a process of mainstreaming HIV for multi-sectoral action to scale up the response.

This monograph serves as a resource to enable a view on scaled up response through multi-sectoral support for risk reduction and impact mitigation of HIV in India. It draws on key achievements and lessons learnt from NACP I, II and III with regard to mainstreaming. The document focuses on the Department of AIDS Control's (DAC) current response to the epidemic, which are priorities under NACP-IV and the rationale that guided the development of these priorities.



II. The HIV Epidemic in India

The recent HIV estimates highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. The estimated number of new annual HIV infections has declined by 57 per cent over the past decade. It is estimated that India had approximately 1.16 lakh new HIV infections in 2011, as against 2.7 lakh in 2000. In percentage terms, the adult HIV prevalence at national level has continued its steady decline from an estimated level of 0.41 per cent in 2000 through 0.35 per cent in 2006 to 0.27 per cent in 2011.

All the high prevalence states show a clear declining trend in adult HIV prevalence. This is one of the most important pieces of evidence on the impact of the various interventions under the DAC and scaled-up prevention strategies and this has been possible as many hitherto untouched areas were brought into the ambit of the programme and a strong evidenced-based approach including mapping of high risk populations was adopted.

However, the low prevalence states of Assam, Chandigarh, Chhattisgarh, Delhi, Odisha, Punjab, Tripura, Jharkhand, Uttarakhand, Arunachal Pradesh and Meghalaya show rising trends in adult HIV prevalence. This underscores the need for the programme to focus more on the states with low prevalence but high vulnerability.

In India, disease prevalence in the general population is still very low. HIV infection is largely concentrated in the high-risk populations. The heterogeneity of the Indian epidemic is well understood with sub-epidemics of different types in different regions of the country.

Evidence shows that among different risk groups, IDUs and MSMs are increasingly becoming more vulnerable to HIV in many states. The latest HIV estimates also confirm the clear decline of HIV prevalence among female sex workers (FSWs) in most states and at the national level, on the whole. The patterns of prevalence in different risk groups are given in Figure 2.

Figure 1:
Estimated Adult HIV Prevalence and Number of PLHA, India, 2007-11

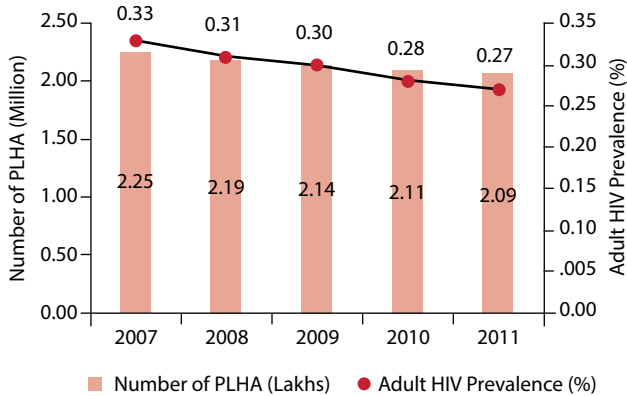
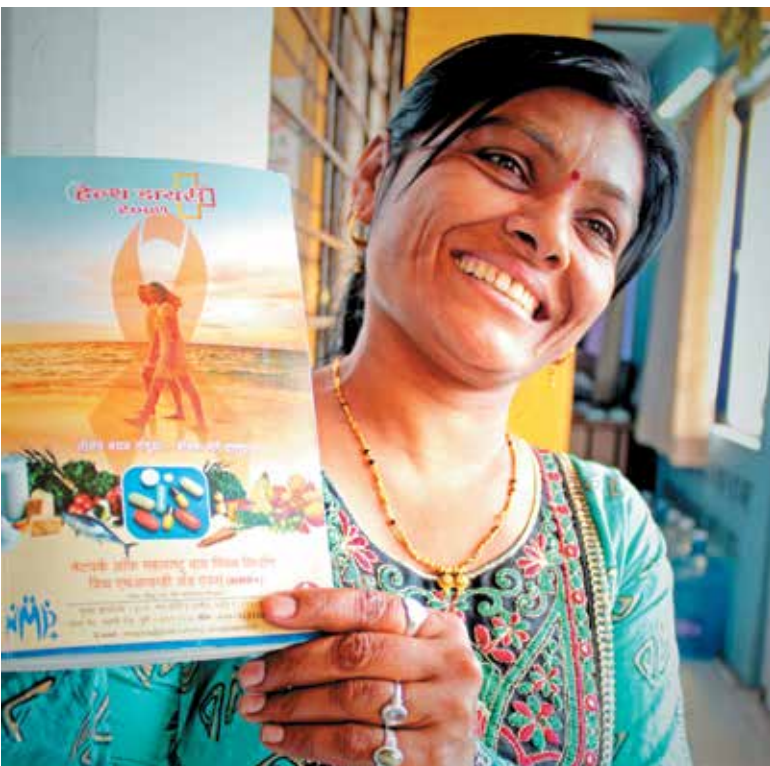
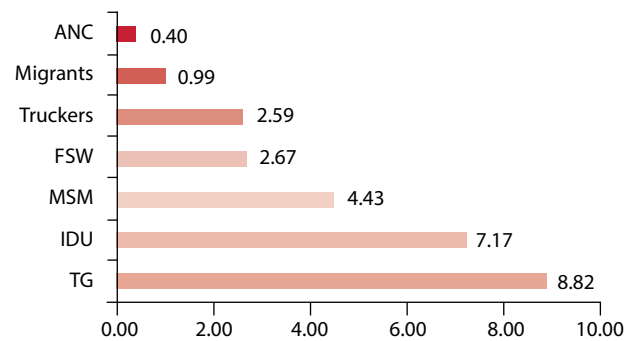


Figure 2:
Pattern of HIV Prevalence (%) in different Risk Groups, India



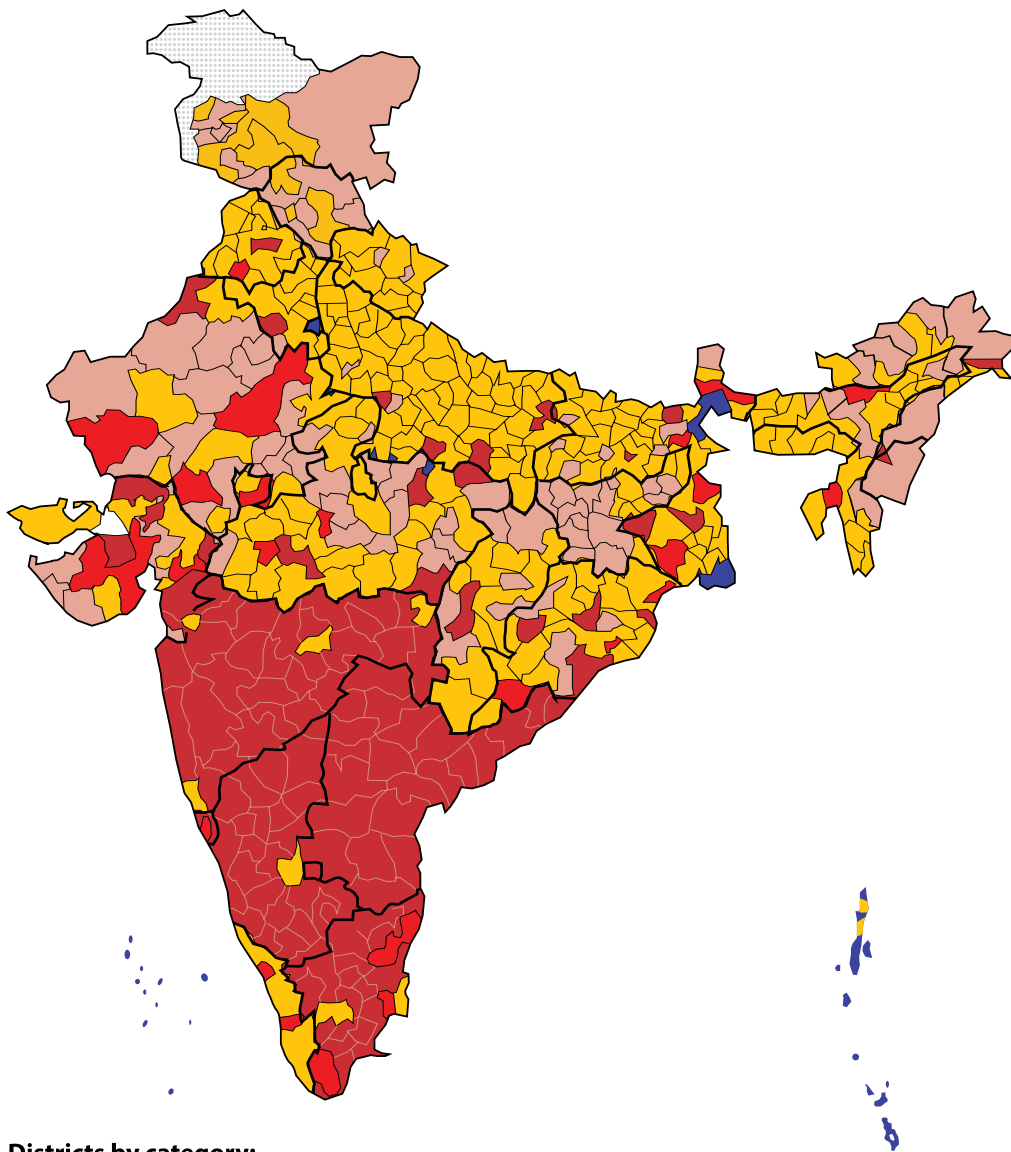
In certain North Indian states, the possible role of migration in fueling HIV epidemics is indicated by the following observations:

- Low levels of HIV among high-risk groups.
- Large volume of out-migration from rural areas to high prevalence areas.
- Higher HIV prevalence among antenatal attendees in rural than urban population.
- Higher prevalence among pregnant women with migrant spouses.

Evidence on vulnerabilities among migrants highlighted by other behavioural studies and corridor studies further corroborate this possibility.


Under NACP III, the focus shifted from national and state level to the high burden districts in the country. These districts have been classified into four categories (A, B, C and D) based on the disease burden in the general population, and prevalence in HRG and vulnerable populations. The heterogeneity of the epidemic is shown in the distribution of A, B, C, D category of districts in different states of India (see Figure 3).

Figure 3:
Geographical Scenario of the Epidemic in different parts of India



Districts by category:

- A: ANC > 1% - 156
- B: ANC < 1%, HRG > 5% - 39
- C: HRG < 5%, - 296
- D: No/Poor Data - 118

 District Categorisation based on Epidemiological Criteria



III. HIV and AIDS Response in India

The Government of India (GoI) has made sustained efforts to prevent the spread of HIV and to provide care, support and treatment to those who are already infected and reach out to the communities at greatest risk. Some of the concrete steps taken in last two decades are:

- **1986:** The GoI constituted a taskforce to study the problem of HIV/AIDS in India.
- **1987:** A National AIDS Control Programme was formulated.
- **1991–99:** A comprehensive HIV/AIDS Control Project Phase I was launched during the VIII Five Year Plan with an outlay of US\$84 million with IDA credit from the World Bank.

National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organisation (NACO) was set up to implement the programme in

1992. This apex body, through the National AIDS Control Programme (NACP), sets out objectives and guiding principles for a phased programmatic intervention. Till now, it has successfully completed three phases of the NACP: Phase I (1992–1999), Phase II (1999–2007) and Phase III (2007–2012).

- **1994–99:** NACP I was launched with the mandate of prevention of spread of HIV in the country.
- **1999–2006:** NACP Phase II launched with an aim to reduce the spread of HIV infection in India and to strengthen India's capacity to respond to HIV epidemic on a long term basis.
- **2007–12:** NACP Phase III was implemented with an aim to halt and reverse the epidemic in India. This was to be achieved by integrating programmes for prevention, care and support, and treatment, strengthening capacity and improving information management.

- **2009:** Constitution of the DAC under Ministry of Health and Family Welfare.
- **2012–17:** NACP IV aims to accelerate the process of reversal and to further strengthen the epidemic response in India through a cautious and well defined integration process over the five years from 2012 to 2017. Its main objectives are to reduce new infections and provide comprehensive care and support to all PLHIVs and treatment services for all those who require it. The main strategies include intensifying and consolidating prevention services, increasing access and promoting comprehensive care, support and treatment.
 - Prevention of parent to child transmission.
 - Focusing on Information, Education and Communication (IEC) strategies for behaviour change in HRG, awareness among general population and demand generation for HIV services.
 - Providing comprehensive care, support and treatment to eligible PLHA.
 - Reducing stigma and discrimination through involvement of PLHA.
 - Decentralising rollout of services including technical support.
 - Building capacities of non-governmental organisations and civil society partners, especially in states with emerging epidemics.
 - Integrating the HIV services with health systems in a phased manner.

Recent trends indicate that many of the states with emerging epidemics are those with relatively poor health infrastructure and weak implementation capacities, governance and ownership of the programme. NACP IV specifically focuses on these areas and will reach out to the high risk, vulnerable and hard-to-reach groups by ensuring effective delivery of HIV services.

NACP IV also addresses vulnerabilities such as migration and injecting drug use, growing treatment needs, and continued stigma and discrimination. Sustaining coverage and intensity of interventions in areas where declines have been achieved will be consolidated gains. Newer strategies are being developed and will be strengthened to address the emerging epidemic.

NACP IV will integrate with other national programmes and align with overall 12th Five Year Plan goals of inclusive growth and development. The key priorities under NACP IV are:

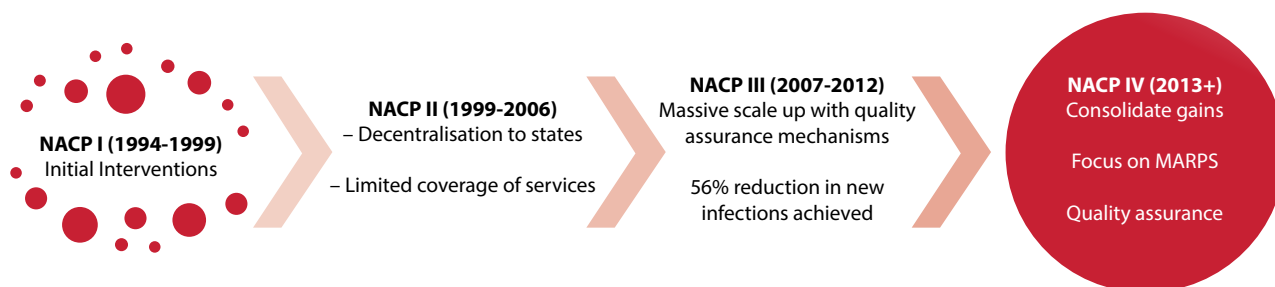
- Preventing new infections through sexual route and injecting drug use.

Taking cognizance of the emerging challenges and focusing on region-specific strategies for evidence-based scale up of prevention and treatment, NACP IV will ensure that the growing treatment requirements are fully met without sacrificing the needs of prevention. In addition, mainstreaming of HIV/AIDS activities with all key central/state level ministries/departments will be a high priority. Collaboration with departments including Social Justice and Empowerment, Tribal Development, Women and Child Development, Railways, Rural Development, Home, Tourism and Public Sector Units will be intensified during NACP IV.

Key Achievements during NACP III:

Targeted interventions (TIs) for high risk groups: The main objective of TIs is to enhance accessibility of high risk groups to key HIV prevention services and improve their health seeking behaviour, thereby reducing their vulnerability and risk to acquire Sexually Transmitted Infections (STI) and HIV infections. TIs provide services such as behaviour change communication, condom

Figure 4:
National AIDS Control Programme – A Snapshot



promotion and clean needle and syringe for people who inject drugs, STI care, referrals for HIV and syphilis testing and linkages with Anti Retroviral Treatment (ART).

There has been a substantial scale up of coverage of FSWs (84.5 per cent), IDUs (80.7 per cent), MSM and transgender (70.6 per cent), truckers (48.4 per cent) and migrants (41.3 per cent) through 1,705 interventions for high risk groups and bridge population. During 2012–13, nearly 218 new TIs have been established till December 2012, surpassing the target of 180. Opioid Substitution Therapy sites in public health settings have been expanded to 52 centres. The proposals for MSM and IDUs for the second phase of Round 9 of the Global Fund have been approved.

A revised migrant strategy for HIV has been rolled out. TIs provide HIV prevention services to migrants at the destination points through outreach and linkages. To address the vulnerability among returnee migrants and spouses of migrants, awareness campaigns and health camps are implemented in the source villages as well as at the major transit points that account for bulk of migration. Employer-led models and migrant tracking systems are also being piloted.

Link Workers scheme: This community-based intervention addresses HIV prevention and care needs of the high risk and vulnerable groups in rural areas and distribution and referrals to counselling, testing and STI services through Link workers. In partnership with various development partners, the Link Worker Scheme is operational in 139 districts as of December 2012, and reaches out to rural HRGs and their partners and vulnerable groups.

Management of Sexually Transmitted Infections: The STI/Reproductive Tract Infections (RTI) services based on the Syndromic Case Management are being provided through 1,112 designated STI/RTI clinics (branded as 'Suraksha Clinic'). Around 42 lakh STI/RTI episodes have been managed as per the national protocol till December 2012 against the target of 64 lakh for 2012–13. Seven regional STI training, reference and research centres have been strengthened. NACO has developed a communication strategy for generating demand for sexual and reproductive services. Preferred Private Provider approach has been rolled out to scale up STI/RTI services to HRG population under TI projects.

Condom promotion: The DAC has successfully implemented four phases of the Condom Social Marketing Programme in 13 states. Around 22.83 crore condoms have been distributed through social marketing up to December 2012 by NACO-contracted

social marketing organisations, against the target of 35 crore pieces for 2012–13. During 2012–13, the DAC has distributed 29.5 crore free condoms by December 2012, against the target of 44.47 crore. Establishment of rural outlets, non-traditional outlets and outlets in TI project areas and truckers' halt-points received special focus. Other initiatives include implementation of Female Condom scale-up Programme and extensive promotion of use of condoms across all programme states.

Blood safety: Access to safe blood has been ensured through a network of around 1,118 blood banks across the country, which includes 34 Model Blood Banks, 175 Blood Component Separation Units, 167 Major Blood Banks and 742 District Level Blood Banks. During 2012–13, a total of 67.56 lakh blood units were collected up to December 2012. The DAC-supported blood banks collected 38.68 lakh units of blood, of which 83.2 per cent was from voluntary blood donation. Other initiatives planned include setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine, and one Plasma Fractionation Centre with processing capacity of more than 1.5 lakh litres of plasma.

HIV counselling and testing services: This programme offers counselling and testing services for HIV infection, which includes three main components – Integrated Counselling and Testing Centres (ICTC); Prevention of Parent to Child Transmission; and HIVTB collaborative activities. HIV counselling and testing services were rapidly scaled up through 4,508 standalone ICTCs, and 8,389 Facility Integrated Counselling and Testing Centres including those under public and private partnership model. A total of 73.25 lakh general clients and 57.1 lakh pregnant women were tested during 2012–13 (till December 2012). 96.4 per cent of HIV positive pregnant women and babies were provided Nevirapine prophylaxis for Prevention of Parent to Child Transmission of HIV. Under the HIV-TB coordination programme, around 9.72 lakh cross-referrals were made between NACP and Revised National Tuberculosis Control Programme during April–December 2012, out of which 32,141 were found co-infected.

Care, support and treatment (CST) for PLHIV: The CST programme provides comprehensive management to PLHIV which includes free ART, psycho-social support, prevention and treatment of opportunistic infections including tuberculosis, and facilitates home-based care. Ten Centres of Excellence and seven pediatric Centres of Excellence provide tertiary level specialist care and treatment (Second line and Alternative First Line ART, management of complicated opportunistic infections and specialised laboratory services). As of December 2012, nearly 17.36 lakh PLHIV have been registered at



380 ART centres of whom 6,04,987 clinically eligible patients (including 34,367 children) are receiving free ART in government health facilities. Nearly 239 community care centres provide psycho-social support, ensuring drug adherence, treatment of opportunistic infections and tracking lost to follow-up cases. Link ART centres and ART PlusCentres have also been established for the decentralisation of first line and second line treatment services.

Laboratory services: The capacity of laboratories for CD4 testing has been strengthened with 264 functional CD4 machines. The assurance of quality in kit evaluation and assessment of HIV testing services through implementation of External Quality Assessment Scheme is given focus. The programme for confirmation of HIV-2 has been rolled out from February 1, 2013, in 13 referral laboratories. Trainings have been conducted on ISO 15189: 2007 for officers from National and State Reference Laboratories.

Early infant diagnosis: Earlier, diagnosis of HIV in a newborn child was possible only after 18 months of age leading to late start of required treatment and care. To address this issue and promote early treatment, Early Infant Diagnosis of HIV for infants and children below 18 months has been rolled out from March 1, 2010. The programme is operational through 1,157 ICTCs

and 217 ART Centres across 31 states. There are seven referral laboratories performing the DNA-PCR test for Early Infant Diagnosis. During 2012–13, 12, nearly 169 HIV exposed infants and children less than 18 months of age had been tested under this programme till December 2012.

Strategic information management: The Strategic Information Management System (SIMS) has been rolled out and strengthened at over 15,000 reporting units across the country. HIV estimations 2012 have been finalised and released after an elaborate and rigorous exercise of modelling. The 13th round of HIV Sentinel Surveillance (HSS 2012–13) has been commissioned at 763 ANC and STD sites across the country from January 1, 2013. Guidelines are being developed for roll-out of national Integrated Biological and Behavioural Surveillance among High Risk Groups and Bridge Population. Programme requirements for evidence and priority areas for HIV/AIDS research have been finalised through a consultative process. A structured Analysis and Research Plan for NACP IV has been developed to fill evidence gaps in the programme through analysis of available data and generation of fresh evidence through HIV/AIDS research. Research in HIV/AIDS including capacity building in operational research and ethics has been strengthened.

Information, education and communication (IEC):

The focus of IEC activities has been on promoting safe behaviour, reduction of HIV stigma and discrimination, demand generation for HIV/AIDS services, and condom promotion. Mass media campaigns were synergised with other outreach activities and mid-media activities. Folk media campaign was up-scaled to 56,090 performances in 2012–13. Adolescence Education Programme is being implemented in 23 states covering 85,000 schools. Red Ribbon Clubs are functional in 12,300 colleges including 396 new clubs formed in 2012–13.

The Red Ribbon Express project, the biggest of its kind in the world, has become a model for such campaigns. In its third phase, the project covered 162 stations in 23 states reaching about 1.14 crore people and training nearly 1.05 lakh district resource persons. Over 90,000 persons were counselled for HIV, of whom over 76,000 were tested for HIV. STI treatment was provided to over 11,000 persons and about 80,000 persons availed of a general health check. Mobilisation of political leaders and enormous support of state governments and district administrations have been key to the success of this project.

Mainstreaming: This facilitates the expansion of key HIV/AIDS services through integration with health systems of various stakeholders. The programme has been able to influence policies, programmes and schemes to provide social protection for PLHIV and HRG. Initiatives are being taken for strengthening convergence of NACP with the National Health Mission. Around 5.19 lakh persons were trained under mainstreaming training programmes.

The 'Inter-ministerial conference for Mainstreaming HIV in India' was organised by the DAC and the United Nations Development Programme (India) in New Delhi on December 18 and 19, 2012. It brought together all concerned ministries and departments on a common platform and facilitated greater understanding and coordination through comprehensive deliberations around the key issues related to mainstreaming HIV.

Achievements of NACP III at a Glance:

Prevention

- Substantial scale-up for coverage of FSW, MSM and IDU through TIs.
- 70 per cent of long distance truckers and 45 per cent of high-risk migrants covered.
- Counselling and testing services scaled up and 74 per cent of the 22 million programme target achieved.
- Nearly 15 million episodes of STI have been managed in partnership with NRHM.
- IEC has been scaled up through mass-media, mid-media and interpersonal communication channels.
- Nearly 5 billion condoms distributed/sold.
- Supply of safe blood ensured in nearly all districts of India.

Care, Support and Treatment

- Scale up of ART – nearly 400,000 PLHA on ART.
- Second line ART treatment initiated.
- Collaboration with RNTCP well established to address HIV/TB co-infections.

Capacity Building

- NACP III Implementation structures and capacities strengthened.
- Training has been provided to the large number of personnel/institutions involved in service delivery.

SIMS

- Strategic Management Information System (SIMS) rollout started.
- Facilitated operational research.
- Programme data effectively used for triangulation and planning.



IV. The Need for Multi-sectoral Response for HIV

The scale of the problem is beyond the reach of the health sector alone and there is an urgent need for multi-sectoral response to stabilising the epidemic and address its negative impact on the social and economic fabric of the country.

Given this challenge, the DAC and UNDP conducted a study in India to understand the social and economic impact of HIV. It was carried out in the six high-prevalence states¹ and examined the micro level impact of HIV/AIDS on households and the macro-level impact on sectors and economic growth.²

This study confirms the argument for a multi-sectoral response to managing the epidemic and its impact. The needs in the context of HIV and AIDS are varied and complex and the above quoted study indicates that it is much beyond being a health issue.

The perspective of the DAC behind mainstreaming HIV is based on addressing deprivations rooted in socio-economic imbalances that 'drive' the epidemic, such as poverty, gender inequality, the lack of adequate housing and sanitation and food insecurity – working with bio-medical interventions like prevention and care in order to create long lasting and sustainable responses.

Though the DAC is working towards improving access to prevention, care and treatment services for infected individuals but, at the same time, due to the stigma prevailing in the society, many of them do not have access to sustained livelihood options, access to basic rights and improved quality of life. With its mandate on prevention, care and treatment, the DAC is not in a position to focus specifically on livelihood and social protection. Thus, the need for establishing partnerships

¹ The six high- states are: Manipur, Nagaland, Maharashtra, Andhra Pradesh, Tamil Nadu and Karnataka. The HIV prevalence (in 2006) in these states was more than 1 per cent among the general population and more than 5 per cent among the high risk groups.

² UNDP. 2006. Socio-economic impact of HIV/AIDS in India.

NACO-UNDP Study 2006 Highlights

- **Increase in household spending: 10 per cent increase on health expenditure by HIV households will reduce their expenditure on education and consumption.**
 - **Increase in health spending: 5 per cent increase in government health spending on HIV will result in 0.67 per cent decline in government savings and 1.16 per cent in investment.**
 - **Decrease in household income: Illness within the HIV household results in loss of income: 66.25 per cent income lost when PLHIV workers were not working and 9.24 per cent lost due to leave/absence from work.**
 - **Unemployment: Unemployment within the HIV households increased from 3.6 per cent to 9.8 per cent – own illness is the most important reason. In the 15-60 age group, the workforce participation rate for PLHIV workers was 70.21 per cent in comparison with 51.06 per cent for non-HIV households.**
-

with departments/ministries and relevant sectors is imperative. This will ensure better use of available resources for risk and vulnerability reduction and impact mitigation of HIV.

The major challenges include reducing the economic impact on households and individuals by ensuring livelihood opportunities, improving access to social protection services, preventing the debt trap and improving access to legal protection services for those infected or affected by HIV.

The epidemic pattern in the country firmly establishes the need for an expanded and broad-based response mechanism to lessen its impact on virtually every sector of society.

- As per the HIV Sentinel Surveillance (HSS) 2011 report, 86 per cent of those infected are in the age group of 15 to 49 years. This is the most productive age group and HIV status affects her/his opportunity for employment and sustained livelihood options. This calls for appropriate policies and actions in the world of work so that these people are not discriminated at their workplaces. Those who require employment opportunity or livelihood options should be given access.
- The HSS also found that, of all HIV infections in the country 39 per cent are among women. The negative impact of HIV among women is much more acute as compared to men and this has been exacerbated given their role in society and their biological vulnerability to HIV. Very often, HIV infected women end up caring for their infected husband and do not have any care and support for

their own health. Thus, there is a need to protect their rights (education, property), improve their access to care, treatment and nutritional support, access to safety net and social protection. This requires a close collaboration with sectors and ministries that work with and for disadvantaged women.

- The latest findings from HSS 2011 show that there is higher Antenatal Clinic (ANC) prevalence (Women tested for HIV in select ANC clinics) in rural areas than urban areas. The rural epidemic in the country is growing and therefore the need for collaboration between sectors, structures and systems that deal with rural development and their increased involvement is imperative in risk reduction and impact mitigation of the epidemic.

The 12th Five Year Plan in India calls for faster, sustainable and inclusive growth and this can be made possible only with integration and multi-sectoral response. There is a need to make appropriate and optimum use of resources and avoid all forms of duplication and wastage.

The National response to HIV and AIDS cannot be seen in isolation and as a vertical, stand-alone effort. As the Hon'ble Prime Minister Dr. Manmohan Singh rightly stated, "the National AIDS Control Programme must move out of the narrow confines of the health department and become an integral part of all government departments and programmes to create a national response, which alone can help reverse the epidemic". This clarion call will also help to further every ministry's mandate for nation building – by creating the right environment in the country for development.



V. Mainstreaming and Partnership – Strategic Approach

Though HIV is preventable, currently there is no cure for it. It can be best described as “a manageable condition”. In this scenario, mainstreaming and partnership for risk reduction, social protection, access to service and stigma reduction become key policy tools to help communities become resilient and cope better.

Mainstreaming and Partnerships in NACP III

During the course of NACP III implementation, a separate mainstreaming cell was established in the DAC which anchored its efforts in mainstreaming HIV across the government, private and civil society sectors at the national, state and district levels. The team also provided technical support to the Ministries of Rural Development, Panchayati Raj, Tourism, Home Affairs, Urban Development and Tribal Affairs at the Centre.³

A geographical approach was applied to the response to ensure proximity and focused effort in the most affected areas, as well as to harmonise national and local policies.

Multi-sectoral responses, or ‘integrated responses’, to HIV interventions worldwide are proving to be a more effective way in dealing with susceptibility to HIV infection, as well as mitigating the burden of the disease on affected communities.⁴ As articulated in various Working Groups’ Consultations for planning of the fourth phase (NACP IV), mainstreaming HIV is premised on six guiding principles. These include, among others: mainstreaming HIV within existing institutional structures; distinguishing mainstreaming efforts as both internal and external domains; identifying ‘entry points’ in sectoral activities where HIV can be targeted; and

³ Following NCA’s meeting on February 16, 2006, a committee consisting of 16 ministries has been constituted. These ministries are those which reach out to large volumes of the population including those that are most vulnerable to HIV and thus need to address HIV urgently.

⁴ UNAIDS/GTZ 2002.

The operational definition of mainstreaming used by NACO ...

“Integrated, inclusive and multi-sectoral approach [that] transfers the ownership of HIV/AIDS issues – including its direct and indirect causes, impact and response to various stakeholders, including the government, the corporate sector and civil society organizations”.

encouraging partnerships with civil society groups as well as the community.

effectiveness and efficiency of the mainstreaming and partnership efforts are monitored at all levels.

Strategy Adopted for Mainstreaming HIV during NACP III:

- Strengthening government’s response to HIV through integrating HIV in the ongoing activities of all its departments.
- Involvement of public and private sectors in HIV programmes through workplace policy and workplace intervention on HIV.
- Involvement of civil society organisations for a greater coverage of the HIV programme, ensuring community ownership.
- Capacity building of PLHIV and facilitating access to social and legal protection through amendment of government schemes/policies in the best interest of PLHIV.

Strategic shift in Mainstreaming and Partnership

Summary of significant shifts in mainstreaming and partnership from NACP III to NACP IV:

- During NACP IV, the strategy for mainstreaming and partnership will be to work with a broad range of stakeholders from government, civil society and the corporate sector in a more balanced, focused and systematic manner.
- Mainstreaming efforts during NACP III focused on garnering support for PLHIV. In NACP IV, both PLHIV and HRGs will be the focus for strategy.
- NACP IV will have a dedicated internal team focusing on mainstreaming and partnership.
- Mainstreaming and partnership actions will be across the board in all states, particularly those with a higher epidemic.
- Monitoring and evaluation of mainstreaming efforts will be strengthened significantly so that

Mainstreaming under NACP IV – The Current Approach

As the next phase of the NACP rolls out, mainstreaming and social protection continues to be key element in the programme design risk reduction and mitigate the impact of HIV among infected and affected communities.

Vision for Mainstreaming

Harmonised and coordinated multi-sectoral national response to achieve NACP goal of accelerating reversal and integrating response.

Objectives and Strategies:

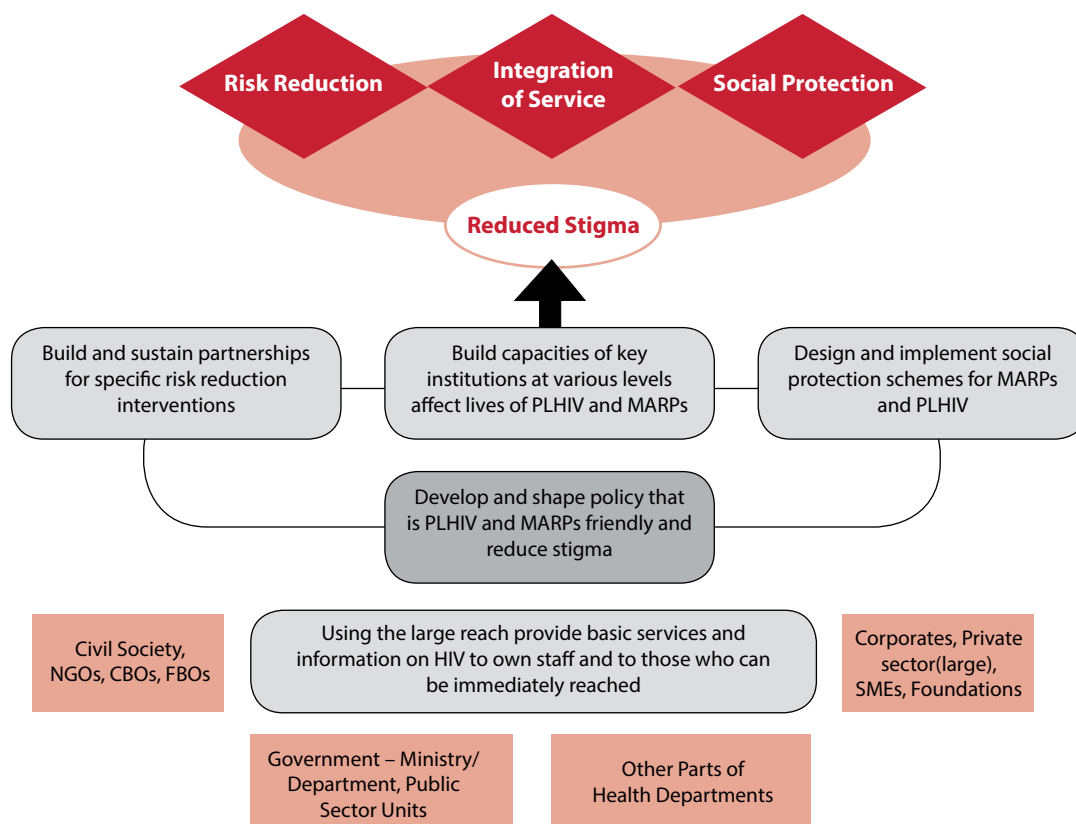
- a) Synergies and coordinated efforts across different players to optimise resource utilisation and maximise impact.
- b) Building capacities of key institutions at various levels to improve the quality of lives of PLHIV and MARPs.
- c) Provision of key HIV services, using existing and large reach to immediate staff and others stakeholders.
- d) Modification of policies, programmes and social protection schemes appropriately to support needs of PLHIV and MARPs.
- e) Creation of an enabling environment through policies, programmes and communication strategies

Key Focus Areas

The key focus areas under NACP IV are:

- Creating an enabling environment through policies, programmes and communication.
- Facilitating expansion of key STI/HIV/AIDS services through integration with health systems of various stakeholders.
- Designing and modifying policies, programmes and

Figure 5:
Vision for Mainstreaming



schemes to support social protection needs of PLHIV and HRG.

Expected outcomes:

- **Enhanced reach and coverage of MARPs** and people who are highly vulnerable to HIV.
- **Expansion of health services-** Utilisation of the vast health infrastructure in the country and resources available with different ministries for implementation of the NACP (improved access to larger population).
- **Provision of appropriate social protection** schemes, by largely modifying existing schemes to make them more PLHIV and MARP friendly.
- **An enabled environment** where the legal, policy and living environments are conducive for the PLHIV and MARP groups to access services.
- **Reduction/elimination of stigma and discrimination** faced by PLHIV and MARPS at family, community and services level.

Key Constituencies

There are four key constituencies for the NACP on its mainstreaming and partnership strategy. They are:

- a. **Government:** This includes ministries and departments (central, state, district, block levels, including convergence with other departments within Health Ministry) public sector undertakings, Panchayati Raj institutions, urban local bodies, armed forces, police and paramilitary forces, Railway Protection Force, judiciary, Parliament/legislature, statutory authorities/regulatory bodies, central and state owned universities, laboratories and special bodies (such as ICMR, CSIR, DRDO).
- b. **Civil Society:** This includes not-for-profit organisations, community-based organisations, faith-based organisations, and Positive Networks. Local self-governance units at the grassroots level in rural and urban setting are also included in this category.
- c. **Corporates:** This includes private sector (large), small and medium enterprises (SMEs), and Corporate Social Responsibility (CSR) foundations.

- d. **Development Partners:** These include World Bank, GFTAM, DFID, UNAIDS, UNDP, UNICEF, ILO, UNFPA, UNWOMEN, BMGF, among others.

Strategies for Mainstreaming and Partnership during NACP IV

The epidemic in the country is changing according to emerging vulnerability factors related to poverty, migration, marginalisation and gender. Therefore the need for collaboration between sectors, structures and systems those deal with these issues, especially migratory and floating population becomes imperative. Based on the need to achieve the above objectives, outcomes and the potential role of the various constituencies, mainstreaming and partnership strategies are outlined here.

A. Mainstreaming for Prevention

Provide information on HIV/AIDS to own staff and those who can be immediately reached through the outreach programmes

Most of the partners mentioned earlier have substantial reach – government ministries/departments, public and private sector in particular – through their vast number of employees, supply chain employees and the health and extension services they provide. These partners will be encouraged to mainstream HIV messaging in the existing mechanisms of information delivery.

Build capacities of key institutions at various levels

Capacity building and technical support are two key roles of NACO, SACS and developmental partners facilitating mainstreaming programmes. To this end, capacity building packages (videos, audio, online and set of trainers, Positive speakers) will be developed and made available to mainstreaming partners. In addition, need-based technical support to various partners will be provided in ensuring that the mainstreaming activities are rolled out successfully. Here, support and partnership with capacity building organisations and PLHIV and HRG groups are critical.

B. Mainstreaming for Scaling Up of HIV/AIDS Services

Integration of HIV/AIDS/STIs with the existing health systems of other ministries

Workplace programmes can raise awareness, support prevention, expand access to information and health services and prevent discrimination of workers infected or sick. Workplace has a vital role to play in the wider



struggle to control the epidemic, as it affects workers and their families, enterprises and the communities which depend on them. HIV has negative effects amongst the workplace in terms of loss of income and benefit, loss of skills and experience, falling productivity and reduced profit. Thus HIV/AIDS needs to become a part of workplace health promotion policies. Discrimination and stigmatisation against women and men with HIV threaten fundamental principles and rights at work, and undermine efforts for prevention and care.

C. Mainstreaming for Social protection

Partnership for mitigating the impact of HIV and AIDS by improving access to social and legal protection for communities infected or affected by HIV

HIV and AIDS can push people and households into poverty, in part by reducing household labour capacity and by increasing medical expenses. In some cases, HIV-related stigma and discrimination marginalises PLHIV and households affected by the disease and exclude them from essential services. The humanitarian case for taking action to prevent the spread of HIV and AIDS is in itself a compelling one. The impact is felt on income, employment, consumption expenditure (especially nutrition, education and healthcare) and savings. To conquer the disease and reduce its staggering burdens on households and families, considerable greater efforts

and resources will be needed. Partnership for mitigating the impact is as important as provision of social and legal protection to communities infected and affected by HIV.

Social and legal protection is a mix of policies and programmes that meet the needs and uphold the rights of the most vulnerable and the excluded. In their comprehensive form, social and legal protection measures include access to rights and entitlements which may be in the areas of nutrition, healthcare, safe shelter, health insurance, legal aid, travel support and so on. In the HIV context, social and legal protection reduces the possibility of an individual becoming infected with HIV, the likely damage HIV can wreak on individuals, households and communities, and enhances the efforts to expand universal access to the most hard to reach.

Social protection measures become HIV sensitive when they are inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV and AIDS. In the light of the strategic importance of social protection to mitigate the impact on people living with HIV as well as to reduce the vulnerabilities of people to infection, the DAC works closely with government departments to identify and advocate for amendment/adaptation of policies and schemes for social and legal protection of marginalised groups.



VI. Initiatives and the Way Forward under Mainstreaming and Partnerships

In continuation of the efforts taken during the NACP III and the inter-ministerial conference held during December 2012, the DAC moved ahead with a focused objective to formalise its partnership with the various departments/ministries. This will support the department in achieving its objectives through collaborative efforts. Memorandums of understanding were developed with 31 departments/ministries to further the process of formalising the partnerships. These were formally shared with the departments/ministries for consideration and approvals.

Keeping in view the larger objectives of mainstreaming: risk reduction, improved access to service and social protection, this chapter summarises the initiatives with each department/ministry entailing the scope and objectives of the partnership. The order of the departments/ministries is based on the objectives of mainstreaming, the progress made in formalising the issue, considering the time when the document was shared with the departments/ministries.

1. Ministry of Housing and Urban Poverty Alleviation

The Ministry of Housing and Urban Poverty Alleviation (MoHUPA) is the apex authority of the GoI at the national level to formulate policies, sponsor and support programmes, coordinate the activities of various central ministries, state governments and other nodal authorities and monitor the programmes concerning all the issues of urban employment, poverty and housing in the country.

Urban areas, which are the driving force behind economies, also tend to provide conditions favorable for spread of infections including HIV. Urbanisation is fuelled by rapid migration which has been clearly identified as driver of the epidemic. The linkages between HIV and urban life are characterised by a large migratory population, clustered housing in slums and poor sanitary conditions which provide heightened vulnerability to HIV.

High population density, presence of transportation hubs and the existence of concentrated groups of vulnerable persons such as (IDUs, sex workers, truckers, MSM) provide conditions of heightened vulnerability to STI and HIV.

In collaboration with the DAC, the Ministry has taken certain initial steps which are summarised here:

- Sensitisation programmes have been conducted on HIV and AIDS thrice for officials from the Ministry, 14 mayors, seven deputy mayors, municipal commissioners, chief officers and president of the standing committee and other stakeholders.
- A special session on HIV and AIDS was facilitated at the National Mayors' Conference on Urban Poverty Alleviation.
- An interactive HIV and AIDS corner has been designed and made available on the official web site of MoHUPA.
- A short 15-minute film has been produced highlighting the correlation of urban life with HIV/AIDS and how urban local bodies can address the prevention, care and support elements at their level.

- A National Convention on HIV and AIDS for Parliamentarians, Zila Parishad chairpersons and mayors held on July 4 and 5, 2011, was attended by more than 100 mayors.
- A draft TOT module on HIV and AIDS has been prepared for sensitisation of mayors and urban local body officials.

The Ministry has introduced a number of policies, programmes and schemes to promote "inclusive" and "slum-free cities" people below the poverty line. The scope for collaboration is as shown below.

Rajiv Awas Yojana: People living with HIV and sexual minorities are mostly from the marginalised communities and housing is one of the basic needs of the HIV infected and affected populations. There is scope of including PLHIV among the weaker section.

National Urban Livelihood Programme: NULM lays particular emphasis the mobilisation of vulnerable sections of the urban population such as SCs, STs, minorities, female-headed households, persons with disabilities, the destitute, migrant labourers, and especially vulnerable occupational groups such as street vendors, rag pickers, domestic workers, beggars, construction workers, etc.

The Ministry has partnered with DAC aiming to:

- Enhance the access of people infected and affected by HIV in the livelihood schemes and programmes of Ministry of Housing and Urban Poverty Alleviation through inclusive approach.
- Enhance the access of people infected and affected by HIV to housing schemes and programmes of Ministry of Housing and Urban Poverty Alleviation through inclusive approach.
- Improve social protection to PLHIV and most-at-risk population (MARPs) through existing schemes and programmes for urban employment, poverty alleviation and housing.

2. Ministry of Rural Development

The Ministry of Rural Development (MoRD) acts as a catalyst effecting the change in rural areas through the implementation of a wide spectrum of programmes which are aimed at poverty alleviation, employment generation, infrastructure development and social security. The Ministry's main objective is to alleviate rural poverty and ensure improved quality of life for the rural population, especially those living below the poverty line. These objectives are achieved through formulation, development and implementation of policies and programmes.

The DAC has been able to collaborate with MoRD in the past for the following initiatives:

Capacity building

- Sensitisation workshops on HIV/AIDS were organised for the officials of MoRD. A village level training manual named *Our Health in Our Hands*, which includes a chapter on HIV/AIDS was prepared for the benefit of swarojgaris. This manual was then distributed to the DRDAs of all the states.
- On January 28–29, 2008, a National Conference of Project Directors of DRDA was held at Vigyan Bhawan, And 611 project directors were oriented on HIV/AIDS at the conference.
- During NACP III (2007– 2012), about four lakh Self Help Group (SHG) members were trained on HIV in the states of Andhra Pradesh, Tamil Nadu and Maharashtra to increase awareness, address stigma and discrimination against PLHIV and empower women to protect themselves.
- Two-and-a-half-hour sessions were incorporated in major trainings of SIRD, which is a nodal agency of training of panchayat members.

Facilitating social protection

- For reaching rural men and women in the unorganised sector through livelihood options, a pilot for building capacity of Rozgaar Sahayaks at NREGA worksites has been implemented in Chhattisgarh and Rajasthan.
- SARAS Melas organised both at central and state levels to promote the products of SHGs are utilised as a platform to make rural population and other visitors aware regarding HIV/AIDS and also market the products made by PLHIV.

Given the need to reach out to high risk groups and most-at-risk population in rural areas, the schemes and programme of this Ministry at the national and state

level have been recognised as an important platform for HIV prevention. It also helps to link up with care and treatment services and provide social protection to infected and affected persons living in the rural areas.

The Department of Rural Development aims to reach out to most disadvantaged sections of the society in its efforts of poverty alleviation and provision of livelihood and employment through its inclusive approach. Since the high risk groups of HIV/AIDS are mostly the poor and marginalised, there is lot of scope of mainstreaming HIV into existing programmes and schemes.

Indira Gandhi National Widow Pension Scheme

(IGWPS) and NSAP. Currently, out of the total PLHIV of 21 lakh persons, approximately 39 per cent of them are women, that is, approximately 8.16 lakh women of which around 50 per cent–60 per cent are widows (as per Positive Women's Network). Thus there are 4–5 lakh widows estimated to be infected with HIV in India. As per the experience of the DAC, out of the expected 4–5 lakh widows infected with HIV, less than only 20,000 widows living with HIV are able to avail the benefit of widows' pension scheme. The major reasons for this low access are (a) they do not meet the criteria of age which should be a minimum of 40 year; (b) they do not meet the BPL criteria or are not living in the marital home, where they may be listed; and (c) they are not able to access the services due to stigma and discrimination. Thus there is need to include all widows infected by HIV/AIDS under the scheme, irrespective of age and BPL criteria.

Aajeevika, National Rural Livelihoods Mission

(NRLM): Livelihood support to PLHIV provides sustainable social protection to PLHIV and MARPs. It ensures coping mechanisms with dignity and self-respect and contributes to risk reduction Under NRLM, target groups are to be determined by a well-defined, transparent and equitable process of Participatory Identification of Poor (PIP). There is scope to include HIV/AIDS under the participatory identification of poor which would reduce stigma and discrimination.

Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS):

In view of the large reach of this programme, there is scope for dissemination of correct information and knowledge about prevention of HIV through peer approaches at work sites. Besides the prevention effort, the employment provided under the programme is an important tool for impact mitigation for those infected and affected by HIV/AIDS.



Automatic inclusion of PLHIV in the BPL list: The DoRD can recommend the automatic inclusion of households with HIV positive persons in the BPL household list to expert committee under the Chairmanship of Prof Abhijeet Sen, Member Planning Commission, for refining the criteria for identification of BPL/beneficiary household. This would facilitate social protection to PLHIV and MARPs under various poverty alleviation programmes and improve their access to schemes pertaining to nutrition, livelihood, employment, housing and social assistance without disclosing their status and without fear of stigma and discrimination.

DoRD provides support for capacity building of rural development functionaries at all levels through the network of training institutes like NIRD, SIRD, etc. There is scope to integrate training on HIV/AIDS under all training (at least one session) for all DRDA officials and other officials. This would ensure sustainability of HIV-sensitive perspectives in all personnel.

Indira Awas Yojana: Housing is one of the basic needs of survival. However, the disclosure of status of HIV infections results in the rejection and seclusion of PLHIV by their own families/neighbourhood and community. The lack of decent shelter increases their vulnerability and helplessness, often pushing them towards physical and sexual exploitation. Provision of safe shelter would

reduce their vulnerability and ensure social protection. Thus there is scope for help for PLHIV under the category of 'Vulnerable groups' under India Awas Yojana.

Reducing stigma and discrimination against PLHIV and MARPs: Given the socio-cultural background of rural areas, it is found that PLHIV and those vulnerable to it face stigma and discrimination. Department of Rural Development has an important role in ensuring that there is no stigma and discrimination against PLHIV. The partnership aims at ensuring:

- Provision of widow pension benefit to all widows infected with HIV/AIDS under Indira Gandhi National Widow Pension Scheme (IGWPS).
- Prioritisation for PLHIV under employment programme (MNREGA) without stigma and discrimination.
- Include PLHIV under Participatory Identification of Poor (PIP) under National Rural Livelihood Mission (NRLM).
- Facilitate access of PLHIV to decent housing under Indira Awas Yojana.
- Build capacity of rural development functionaries through state and district level training centres.
- Take up the issue of automatic inclusion of PLHIV under BPL household list through appropriate structures and processes.

3. Ministry of Tribal Affairs

The Ministry of Tribal Affairs is the nodal Ministry for the overall policy, planning and coordination of programmes for the development of Scheduled Tribes. It is providing focused attention on the integrated socio-economic development of the Scheduled Tribes. To this end, the Ministry undertakes activities such as social security and social insurance to the Scheduled Tribes, Tribal welfare planning, project formulation, research, evaluation, statistics and training, promotion and development of voluntary efforts on tribal welfare, etc. Rural Indian tribes are anthropologically distinct with unique cultures, traditions and practices. Over the years, displacement and rapid acculturation of these populations has led to dramatic changes in their socio-cultural and value systems. Tourism, mining, displacement and other external influences increasingly lure tribal women/girls into sex work, leading to exploitation by external agents and human trafficking. Needless to say, the majority of the tribal population in India is affected by these contextual factors, which have a bearing on their vulnerability to various communicable diseases including STI/HIV.

Tribal populations are vulnerable to various health problems, especially communicable diseases including HIV/AIDS because of their community sexual norms. This is often compounded by poor penetration of media, low level of literacy and awareness and lack of availability of health services, in general, and HIV/AIDS related services, in particular. Tribal populations have been one of the priority groups under the NACP due to low awareness, remote location and poor access to health services, high migration, and health seeking behaviour in most of the states.

The DAC, jointly with Ministry of Tribal Affairs, designed the Tribal Action Plan (TAP) and operational guidelines for the TAP to improve the access of tribal people to information, prevention and comprehensive care and support under NACP III. The TAP was rolled in 65 ITDAs out of total 192 ITDP areas falling in high prevalence districts. An amount of Rs 5 lakh per ITDP has been allocated for IEC activities and for training health functionaries at the grassroot level.

Under TAP, a state-level workshop was held for participative planning. The key participants included TDD officers, TRI officers, NGOs working on tribal issues, Ashram Shala officers, DAPCU officers and SACS officers. Training of trainers was done to create a pool for capacity building of all personnel involved in tribal development in most of the states. Other major activities included capacity building, staff of ashram schools and tribal community leaders, preparation of IEC and learning material in tribal languages and folk programmes in remote areas. The NACP aims to improve the access of HIV/AIDS services in tribal areas through building the capacity of traditional healers and non-qualified private practitioners to practice syndromic case management and reimburse cost of travel to ART centres and incidental expenses for the attendee and a companion.

The Ministry has agreed to expand this scope to all tribal areas and mainstream HIV in the ongoing schemes and programmes as suggested below:

- Inclusion of HIV/AIDS in the Draft National Tribal Policy (will be based on the high level committee's recommendation).
- Awareness on HIV through inclusion in the 194 Tribal Area Development Programme.
- Awareness on HIV through inclusion in Modified Area Development Approach (MADA) pockets (259) and clusters (82).
- Information Education and Communication through tribal haats/fairs.
- Expansion of HIV/AIDS related services as inclusion in existing health infrastructure under Tribal Area Development Programme.
- Leverage on resources for IEC and benefit on social protection to people infected and affected with HIV.
- Capacity building: Ashram school teachers.
- Sensitisation of traditional healers, including HIV/AIDS under operational research being conducted through CBO/NGO and TRIs.

4. Ministry of Social Justice and Empowerment

Ministry of Social Justice and Empowerment (MoSJE) works towards achieving equitable treatment to those sections of society which suffer due to social inequalities, exploitation, discrimination and injustice. It is the nodal Ministry for the empowerment of the disadvantaged and marginalised sections of the society. It plays a catalytic role in promoting voluntary action, formulating and implementing the policies to reach the marginalised communities. All the programmes are meant to prevent neglect, abuse and exploitation and provide assistance and mainstream those deprived of their rights. The Ministry has been implementing various programmes/schemes for social, educational and economic development of the target groups. The DAC has been collaborating with the MoSJE for developing policies and programmes primarily for risk reduction and improving access to social protection. Some of the activities which were undertaken jointly are presented here.

Department of Social Justice and Empowerment

The Department is developing the National Policy on Prevention of Alcoholism and Substance Use and Rehabilitation. There is scope to include adequate focus on "How Alcoholism and Substance Use" enhance chances of risk behaviour and contribute to vulnerability to number of health problems including STI/HIV. Similarly, the component of rehabilitation has the scope to include persons infected and affected by HIV.

The Department is making efforts to improve evidence and information on the extent, pattern and trends of drug abuse in the country. These efforts have scope to include adequate focus on understanding pattern and trends of their risk behaviour, which makes them vulnerable to STI/HIV. Secondly, the evidence and information gathered by the Ministry can be strategically used for planning appropriate targeted interventions by the DAC.

The Department is providing detoxification and rehabilitation for IDUs through NGOs contracted to run the Integrated Rehabilitation Centres for Addicts (IRCA) spread across the country. The DAC is represented in the National Consultative Committee on Demand Reduction (NCCDR) constituted by the MoSJE. The MoSJE is represented in the National Technical Resource Group on Injecting Drug Use constituted by the DAC. This collaboration needs to be sustained and strengthened.

Therefore, the DAC is in negotiation with the MoSJE to collaborate on the following:

- Inclusion of FSWs, MSM, transgender, IDUs and People living with HIV/AIDS as priority groups for social defence programmes.
- Enhancing linkages and effective coordination between Injecting Drug Users Targeted Intervention (IDUs-TI) supported by DAC and Integrated Rehabilitation Centre for Addicts (IRCAs) supported by DSJE.
- Developing welfare schemes aiming at social inclusion and empowerment of hijras-transgender people who face extreme social alienation, enhancing their vulnerability to HIV.
- Addressing risk of HIV transmission among all substance users through preventive risk reduction messaging on HIV/STI and linkages with ICTC and other services.
- Working towards empowerment of discriminated and vulnerable groups like FSWs and hijras-transgender people by nurturing a supportive and congenial environment which promotes human development by safeguarding human rights of all, providing social protection and rendering psycho-social care.

Department of Disability

The Department of Disability deals with person with disabilities and has initiated a number of rehabilitation schemes. According to Census 2011, there are 2.19 crore persons with disabilities (PwD) in India which constitute 2.13 per cent of the total population. People with disability are often marginalised and are vulnerable in the community due to lack of access to information, low literacy rate and stigma. This enhances their vulnerability to sexual exploitation. People with disabilities, especially women, are considered more vulnerable for contracting HIV. They may be sexually exploited in the home setting as well as in institutional care.

In the context of HIV, PwD are also found within every high risk group such as sex workers and their clients, IDUs, MSM, orphans, etc. People with disabilities are, therefore, exposed to the same risk factors for HIV as any other person.

The Department of Disability has agreed to play a crucial role in prevention and mitigation of its impact by:

- Reaching large numbers of people with disabilities with information on STI/HIV/AIDS and related services.
- Strengthen HIV and AIDS prevention initiatives for persons with disability.
- Reduce social stigma and discrimination of people living with HIV/AIDS and their family or other affected groups.
- Reaching out to large numbers of people with the message of voluntary blood donation.

5. Ministry of Women and Child Development

The Ministry of Women and Child Development is the nodal Ministry for development and empowerment of women and children. Its vision for women is “promoting social and economic empowerment of women through cross-cutting policies and programmes, mainstreaming gender concerns, creating awareness about their rights and facilitating institutional and legislative support for ensuring access to their rights and develop to their full potential.

The Ministry has taken a number of initiatives in collaboration with the DAC for prevention of HIV infection among women and providing support to children who are infected or affected by HIV and AIDS. The following steps are related to policy measures, capacity building and social protection of women and children:

- A National Policy on Children and AIDS in India has been prepared by the Ministry and provision of services for ‘children affected by HIV/AIDS’ has been incorporated in the Integrated Child Protection Scheme (ICPS).
- Integration of information on Prevention of Parent to Child Transmission (PPTCT) in all training programmes for CDPOs, Supervisors, Anganwadi workers has been ensured in the training curriculum by the National Institute of Public Cooperation and Child Development (NIPCCD).
- A TOT module has been developed for reaching out to self help groups titled, ‘Shaping Our Lives: Learning to Live Safe and Healthy’. The module has been developed in English and Hindi, and has also been translated in Bengali, Malayalam, Marathi, Kannada, Telugu and Gujarati. Approximately 1.5 lakh frontline workers including AWW were trained in FY 2011–12. Approximately 30,000 AWW have been trained in the current FY 2012–13. At least one batch of AWWs is trained at all halt stations of the Red Ribbon Express in the third phase.
- In an effort to improve the access to social protection of women and children, four states (Gujarat, Tamil Nadu, Rajasthan and Orissa) have extended nutritional supplements under the ICDS for children and women living with HIV.

Like many other epidemics, the vulnerability as well as impact of HIV/AIDS is much more severe on women than men. Biological, socio-cultural and economic factors make women and young girls more vulnerable to HIV and AIDS. The vulnerability of women to HIV in India is further exacerbated due to their hierarchically

lower position in society, Added to this are the specific vulnerabilities of certain social groups such as FSWs, spouses of migrants and truckers, women migrants, single women, adolescent girls, widows infected and affected by HIV and AIDS, and transgendered women. Currently, 39 per cent (8.16 lakh) of estimated HIV infections are among women. The scope for mainstreaming HIV within the Ministry is as indicated here.

1. For girls and women infected and affected with HIV

Prevention of Parent to Child Transmission

(PPTCT): The PPTCT programme aims to prevent the transmission of HIV from an HIV infected pregnant mother to her newborn baby. Pregnant women found HIV infected are currently provided treatment to prevent transmission of HIV from mother to child. This treatment reduces the risk of HIV transmission to less than 5 per cent, but demands close monitoring of the infected pregnant mother from 14 weeks of pregnancy, through delivery and until cessation of breastfeeding. Based on estimated HIV infections among adult females and assumptions on effect of HIV on fertility and mother to child transmission rates, it is estimated that around 38,000 HIV positive pregnant women needed PPTCT services in 2011. The overall number of pregnant women needing PPTCT services has declined in the country from 51,000 in 2007 to 38,000 in 2011. However, in view of the national goal of elimination of transmission of Infection from Parent to Child, there is urgent need to reach all the estimated HIV positive pregnant women with information and services, which becomes a challenge especially in the context of low institutional deliveries in some states. The MoWCD needs to ensure capacity of ICDS and ICPS functionaries to reach pregnant women, promote HIV testing and referral for PPTCT services and enhance their access under Indira Gandhi Matritva Sahyog Yojana (IGMSY), a conditional Maternity Benefit Scheme.

Risk reduction among women and girls: Reducing sexual transmission of HIV by 50 per cent by 2015 requires scaled-up access to comprehensive information and non-judgmental services for women and girls. Even in cases where HIV knowledge exists, stereotyped gender norms can act as barriers for women to negotiate condom use and otherwise protect themselves from HIV.

- Include HIV/AIDS in the training of ICDS/ICPS/SHGs/ Swayamsidha programme and women PRI members to disseminate information about HIV prevention and reduce stigma and discrimination for women and children living with HIV.
- Include HIV/AIDS in the training and guidelines of Kishori Shakti Yojana and Sabla Scheme for life skills education, and messages on HIV/AIDS prevention for young girls and women.

Skill building and employment for girls and women in the high risk and vulnerable groups as well as those infected with HIV/AIDS: Facilitate support to training and employment programme (STEP) for HIV-infected women, high risk groups such as FSWs, female drug users, victims of violence and transgender people and for HIV affected women (wives and widows of HIV positive persons).

Social protection for women infected and affected by HIV/AIDS: There is scope for specifically designed programmes for social protection of women infected and affected by HIV/AIDS support and safe shelter for such women covering their nutrition, shelter, skill building and employment.

2. For children infected and affected by HIV

HIV infection in extremely young children is especially fatal. Young children progress through the disease at a much faster rate, thus making early detection, nutritional supplements and medical treatment essential for survival. Currently 7 per cent (8.16 lakh) of estimated HIV infections are among children (below 15 yrs). The proportion has increased from 4.4 per cent – 7 per cent in 2011, although absolute numbers remain approximately the same. Deaths among HIV infected children account for 7 per cent of all AIDS-related deaths. For providing treatment and care to HIV infected children, a National Pediatric HIV/AIDS initiative was launched in November 2006. Since then, around 31,500 HIV infected children have been receiving free ART. Beyond the direct impact of being infected by AIDS, children are impacted by their parent's infection. Many children are orphaned and highly exposed to abuse, exploitation and neglect because of a loss of a parent(s) or guardian. Children living with the disease experience a great deal of social stigma and discrimination resulting in their marginalisation from essential services such as education and health.

The mission of MoWCD for children is “ensuring development, care and protection of children through cross-cutting policies and programmes, spreading awareness about their rights and facilitating access to learning, nutrition, institutional and legislative support for enabling them to grow and develop to their full potential”.

6. Ministry of Panchayati Raj

Ministry of Panchayati Raj is steering efforts towards three broad areas of local self governance: empowerment, enablement and accountability. It is playing a lead role in building/strengthening institutions, systems, processes, etc, so as to ensure efficiency, transparency and accountability in the Panchayats.

Panchayats are the roots of democracy. Realising their enormous potential, the GoI passed the 73rd Amendment which embodies the concept of integrated governance. It clearly brings people's planning to the forefront and paves the way for ensuring grassroots participation in governance, providing enormous powers to these institutions. Being the nodal unit for planning and implementation of various activities, Panchayats can facilitate multi-sectoral response. The network of Panchayati Raj institutions (PRIs) consisting of 581 District Panchayats, 6351 Block Panchayats and over 6 lakh villages across the country offer one of the largest institutional networks for mainstreaming HIV. Moreover, with one-third representation from women and proportionate representation from scheduled castes and scheduled tribes, this network renders a unique opportunity to make the mainstreaming task more gender sensitive and inclusive in nature.

Panchayats have been playing a critical role in the development of rural areas. The role of the Panchayats in this context becomes very crucial for the DAC to scale up prevention and care activities to the rural areas. The Ministry of Panchayati Raj has been collaborating in mainstreaming HIV within the Panchayati Raj agenda.

Mainstreaming effort with the Ministry has resulted in issuance of a directive by the Ministry to include a two-and-a-half-hour session on HIV during regular PRI trainings. As a result, 45,943 PRI members have been trained since 2009 through the State Institutes of Rural Development (SIRD) in several states.

A national campaign on HIV/AIDS Prevention, Care and Support by PRIs was launched by the Ministry of Panchayati Raj on November 28, 2007, which set on track certain initiatives. These include: publication of an information booklet on HIV/AIDS titled *Gram Sandesh* and guidelines on HIV response within Panchayats titled *Mahila Evam Yuva Shakti Abhiyan*. A short film on how PRIs can address prevention, care and support of HIV/AIDS at the village level has also been produced.

7. Ministry of Law and Justice

The Ministry of Law and Justice (MoLJ) comprises the Legislative Department and the Department of Legal Affairs. The Department of Legal Affairs is concerned with advising the various ministries of the central government while the Legislative Department is concerned with drafting of principal legislations for the central government, that is, Bills to be introduced in the Parliament, Ordinances to be promulgated by the President. It also covers "Legal Aid to Poor" as per Article 39A of the Constitution of India, which provides for free legal aid to the poor and weaker sections of the society and ensures justice for all.

The National Legal Services Authority (NALSA) has been constituted under the Legal Services Authorities Act, 1987, to monitor and evaluate implementation of legal aid programmes and to lay down policies and principles for making legal services available under the Act.

The MoLJ has been involved with the National AIDS Control Programme particularly in the area of facilitating access to legal protection for HIV infected and affected population. The following is a summary of some of its activities and achievements:

- The NALSA, in partnership with UNODC ROSA, organised a Colloquium on "Justice Delivery in Human Trafficking Crimes" for judicial officers, prosecutors and police officers in 2008 at Vigyan Bhawan, New Delhi.
- A Judicial Colloquium on "Human Rights, with special reference to HIV/AIDS and the Law" was organised by the Human Rights Law Network in association with the Goa State Legal Services Authority at the International Centre Goa in 2009.
- LACs have been established to address the grievances of women with regard to the legal issues. The Tamil Nadu SACS partnered with the State Legal Services Authority (SLSA) to implement the programme. LACs are being implemented in 16 districts, that is, Namakkal, Dindigul, Madurai, Cuddalore, Tirunelveli, Villupuram, Chennai, Trichy, Dharmapuri, Krishnagiri, Salem, Theni, Thiruppur, Karur, Tuticorin and Kanyakumari. The process to establish LACs in the remaining districts of the state

continues. Similar models are also in place in the states of Andhra Pradesh, Kerala, Karnataka and Madhya Pradesh.

- In February 2011, NALSA partnered with UNDP and organised the first National Seminar on Transgender and the Law.
- In October 2012, NALSA has filed a PIL in the Supreme Court of India on issues of transgender person's rights, social protection and legal identity.

The Department of Legal Affairs can play an important role in reducing social stigma and discrimination. PLHIV are often not aware of their rights and entitlements. The stigma and discrimination associated with the epidemic leads to violation of basic rights and the worst sufferers of violation are PLHIV and their families, orphan children infected and affected with HIV, most at risk population like FSWs, MSMs, IDUs, transgender and hijras, etc. In some cases, service providers like outreach workers and peer educators from Targeted Intervention Projects those who are directly associated with the HIV/AIDS prevention and control programme run by NGOs are also being harassed and their rights violated.

Thus, legal protection is one of the emerging needs for people infected and affected with HIV, most at risk population and service providers. It is proposed to include people infected and affected with HIV under the "Access to Justice for Marginalised People" to empower them by providing legal literacy and to demand legal services, at the same time supporting the national and local justice delivery institutions to bring justice to the poor.

- Promoting legal awareness amongst the Networks of People Living with HIV, CBOs of marginalised community and civil societies towards reducing incidence of violation of rights and discrimination.
- Strengthen the mechanism of legal aid by NALSA, SALSAs and DALSAs, Bar Council and para-legal workers to target groups including PLHIV and affected groups, FSWs, IDUs, MSMs, transgender persons, hijras, etc.
- Enhance access to justice by target population.

8. Ministry of Human Resource Development

Ministry of Human Resource Development (MoHRD) is responsible for formulating the National Policy on Education and works towards the goal of nation building through planned development, including expanding access and improving quality of the educational institutions throughout the country.

The Department of School Education and Literacy within the ministry is responsible for “universalisation of education” and providing free and compulsory education, a right of every child, in the age group 6–14 years. The Rashtriya Madhyamik Shiksha Abhiyan has been introduced as a step to universalise secondary education in the country through number of domains: elementary education, secondary education, adult education, vocational education and teacher education. The Ministry has been involved with the DAC through the Adolescent Education Programme (AEP) for risk reduction. The AEP is one of the key policy initiatives of the NACP. The MoHRD and DAC collaborated to develop this school-based programme that has been implemented across 144,409 secondary and senior

secondary schools in the country. The objective is to reach out to about 33 million students across India. Under the programme, teachers and peer educators are trained who, in turn, conduct the HIV awareness programme amongst the student community. The programme has covered 50,570 schools so far. They have been provided reference material, which has been developed by the DAC in collaboration with the Ministry and vetted by the NCERT.

Department of School Education and Literacy (MoHRD) has agreed and also set up a joint working group in collaboration with the DAC to reach adolescents, students of both secondary and higher secondary schools, with the information on HIV/AIDS. It will also reach “out of school” youth through integration of HIV/AIDS related information in special courses like non-formal education, adult literacy programmes, Mahila Samakhya, etc. It will help to reduce social stigma and discrimination in education settings. The joint working group looks forward to implement the activities laid down in the plan of action which is summarised here.



Elementary education:

- Sarva Siksha Abhiyan and Mid-Day Meal: Inclusion of clause for “zero stigma and discrimination” against children living with HIV in the guidelines and directives.
- Mahila Samkhya Programme: Inclusion of information on prevention of HIV, and with special focus on women vulnerability and referral for PPTCT in the Mahila Samkhya curriculum.

Secondary education:

- Universal implementation of Adolescent Education Programme.
- Inclusion of clause for “zero stigma and discrimination” against children living with HIV in the guidelines and directives.

Adult education:

- Inclusion of information on prevention with special focus on women vulnerability.
- Vocational education: Inclusion of information on prevention with special focus on youth vulnerability, linkages to RRC and voluntary blood donation.

Teacher education:

- Network of national autonomous bodies of National Council of Educational Research and Training (NCERT), National University on Educational Planning and Administration (NUEPA), six Regional Institutes of Education (REIs):
 - Reaching out to the large number of students from secondary and higher secondary schools regarding HIV/AIDS related information.
 - Reaching out rural women with information on prevention of HIV and PPTCT service through Mahila Samakhya programme and Adult Education Programme.
 - Reaching a large youth population with information on prevention of HIV and promoting voluntary blood donation.
 - Ensure “zero stigma and discrimination” against children infected and affected by HIV in the schools.

Department of Higher Education

Department of Higher Education is responsible for creating a robust and vast system of higher and technical education. It covers university education, technical education distance education, language education and is responsible for the overall development of the basic infrastructure of Higher Education sector. The Department looks after the expansion of access and qualitative improvement in the higher education through world class universities, colleges and other institutions.

The higher education sector has witnessed a tremendous increase in its institutional capacity since independence. It can play a crucial role in awareness generation among youths. It will also support the reduction of any incidence of stigma and discrimination against PLHIV primarily in higher education settings. The formation of Red Ribbon Clubs in colleges and universities, initiated by the DAC in partnership with MoHRD, will address youth’s vulnerability to HIV/AIDS. Red Ribbon Clubs can play a crucial role in creating awareness on blood donation, anti-drug use, etc. The Red Ribbon Club programme is being implemented across the country through SACs.

The Department has entered into a formal partnership with the DAC with the objective of (a) reaching large numbers of students on HIV/AIDS information and knowledge and importance of voluntary blood donation through Red Ribbon Club programmes in colleges, institutions and universities providing technical and higher education; and (b) reduce social stigma and discrimination in colleges, universities and institutions providing technical and higher education.

A joint working group has been constituted for providing strategic guidance, which also reviews the activities undertaken as per the Memorandum of Understanding.

9. Ministry of Youth Affairs and Sports

Department of Youth Affairs

The Department of Youth Affairs aims at optimally utilising the creative energies of the youth by involving them in various nation-building activities. It acts as a facilitator and catalytic agent, linking them to other ministries/departments such as Education, Employment and Training, Health and Family Welfare, etc, through the NSS and NYK. Currently, the NSS has more than 3.2 million student volunteers on its rolls, spread over 298 universities and 42 (+2) Senior Secondary Councils and Directorates of Vocational Education all over the country. Since the inception of the NSS, more than 3.75 crore students from universities, colleges and institutions of higher learning have benefited from its activities. The Nehru Yuva Kendra Sangathan (NYKS) aims to channelise the power of the youth in the age group of 13–35 years on the principles of voluntarism, self-help and community participation. It has established a network of youth clubs in villages, and Nehru Yuva Kendras have been set up. The NYKS has been engaged in identifying and harnessing youth power by forming Youth Clubs at the village level and involving them in nation building activities. The core strength of the NYKS lies in its network of youth clubs that are village-based organisations working for community development and youth empowerment.

Vulnerability to HIV among young people cannot be completely ignored. In the absence of the right guidance and information at a young age, they are more likely to experiment with sex, leading to high-risk behaviour. The prevalent social stigma and discrimination is another challenge. Though NACP Phase III has developed excellent and appropriate HIV-reduction strategies in reaching out to high-risk vulnerable groups and the youth, the further focus on national programmes is to strengthen response to HIV with no incidence of any sort of social stigma and discrimination to PLHIV.

The DAC has been working with both NSS and NYKS in several of its risk reduction programmes and activities; the latter has also been associated in voluntary blood donation programmes. They have been also involved as volunteers for the Link Workers scheme as well as for the Red Ribbon Express in Phases I, II, and III. As on date, 13,100 Red Ribbon Clubs have been constituted and are functional in colleges, and the NSS has been involved in setting up these clubs in most of the colleges.

Reaching out of school: Youths who have never attended school, have had no formal education or have dropped out of school constitute the special group of 'out-of-school youth' vulnerable to STI/HIV infection. Women from amongst the 'out-of-school youth' are married early or are subjected to sexual abuse. The Draft 'Out-of-School Youth Strategy' under the NACP aims to create awareness of HIV/AIDS among the out-of-school youth and to build negotiation/resistance skills against substance use, and empower them as responsible young adults to take the right decisions on safe sexual behaviour and practices. The Department of Youth Affairs can support the DAC in rolling out this strategy.

Reaching young women: Young girls and women are at an increased risk of contracting HIV due to the practice of early marriages. As observed, HIV prevalence among adult males is 1.5 times more than adult females; but in a younger population, HIV prevalence is equal among both the sexes at 0.11 per cent. This specifically points to the need to reach young women in a more focused manner and empower this group with negotiation skills for safe sexual behaviour.

Reaching migrant youth: The latest HIV Sentinel Surveillance clearly points out the relation between migration/mobility and higher vulnerability to STI/HIV infection. As per a NSSO report on 'Migration in India' 2007–08, 64th Round (July 2007–June 2008), approximately 50 per cent of the migrants in the country are between the ages of 15–29 years. This makes it imperative for the NACP to reach the youth with HIV prevention information and services.

The Department of Youth Affairs has signed a Memorandum of Understanding with the DAC for the following:

- Integrating HIV/AIDS in the Draft National Policy for Youth, 2013.
- Integrating HIV/AIDS in the training manuals and modules of the NYKS and NSS.
- Ensuring training of all the functionaries of the NSS and NYKS on HIV/AIDS to reach the youth across the country and enhance their access to counselling and testing services.
- Promoting blood donation among the youth across the country through the wide NSS and NYKS network in the country.
- Facilitating accessibility to STI/HIV-related services provided under the NACP for the youth.

Department of Sports

The Department of Sports under the Ministry of Youth Affairs and Sports (MoYAS) is responsible for taking various steps to promote good governance practices in the management of sports at the national level, in pursuance of national sports policies. The Department has laid down procedures for effective coordination among various agencies for the promotion of sports and extend the infrastructure, training and other facilities required to sportspersons for achieving excellence in international events.

The need for partnership with the Department of Sports was felt keeping in view the recent evidence between vulnerability to HIV and mobility/migration. Since sportspersons are likely to be travelling or staying away from home for long durations, the need for raising awareness levels among them regarding risk perception and safe sex is considered important.

HIV transmission and sports participation: In India, like most countries, there is an official policy of non-disclosure of HIV status. Sportspersons are not under any obligation to reveal their HIV status, although they are discouraged from participating in sports such as wrestling and boxing. The result of this policy of non-disclosure is that all injuries on the sports field are treated as if the injured person could be HIV-positive.

- All injured sportsmen and women who have bleeding wounds are sent off the field until they have been treated and the bleeding has stopped.
- If sportsmen were to inject anabolic steroids, or any other performance enhancer, using the same needle, they could easily transmit HIV to each other, should one of them be HIV-positive.

Participation in sports benefits those who are HIV positive. Judicious exercise strengthens the immune system and better equips the body to fight HIV, and to delay the onset of AIDS. Thus sports can become an important part of positive living.

Sportspersons are normally seen as positive icons of healthy living – they have the potential to shape social norms. They can be instrumental in promoting voluntary blood donation and also addressing the social stigma associated with HIV/AIDS.

The Draft Sports Policy 2007, of the GoI, recognises the contribution of physical education and sports to personal development – especially youth development, community development, health and well-being, education, economic development and entertainment – and in the promotion of international peace and brotherhood. With respect to health and well-being, the Draft Policy recognises how sports can contribute to reducing stigma attached to diseases like HIV/AIDS.

The Draft Sports Policy also aims to make special efforts to reach 'out-of-school youth' and rural youth through various sports activities. This segment is vulnerable to HIV/AIDS also due to the lack of information and risk-taking behaviour. There is scope to integrate information on prevention of HIV in the activities planned for this group.

Thus, the Department of Sports can play a crucial role in supporting the national response to HIV/AIDS through reducing vulnerability among the youth, and addressing social stigma and discrimination.

The Department of Sports (MoYAS) has entered into a Memorandum of Understanding with the DAC with the following objectives in mind:

- Reaching large numbers of youths engaged in sports activities at the village, district and state levels with information on STI/HIV/AIDS prevention and related services.
- Building the capacity of sports educators, administrators and coaches on 'Minimising the risk of HIV transmission on and outside the sports field'.
- Involving youth organisations, sports federations, etc, in HIV/AIDS prevention activities.
- Promoting awareness generation through appropriate hoardings and banners in prominent places, including in sports-related buildings/ infrastructure during state/national events and tournaments.
- Promoting sports as a medium of positive living through showcasing successful PLHIV.
- Involving eminent sports personalities for addressing social stigma and discrimination associated with HIV/AIDS.

10. Ministry of Home Affairs

The Ministry of Home Affairs (MoHA) is a key Ministry with a wide spectrum of responsibilities, the principal being the internal security of the country, the management of the Central Armed Police Forces, border management, centre-state relations, administration of Union Territories (UTs), disaster management, the administration of the Foreigners Act and allied matters, Census and Human Rights. It has six departments and 18 divisions.

The Department of Internal Security deals with the Indian Police Service, Central Armed Police Forces, internal security, law and order and other major issues. With a total strength of more than 21.25 lakh, India has one of the largest police forces in the world. Out of this, nearly 9 lakh comprises the Central Armed Police Forces, including approximately 4 lakh in the State Armed Police.⁵

The Central Armed Police Forces include seven forces under its wings: Central Reserve Police Force (CRPF), Assam Rifles (AR), Border Security Forces (BSF), Central Industrial Security Forces (CISF), Indo-Tibetan Border Police (ITBP), National Security Guard (NSG), Sashastra Seema Bal (SSB) and Special Protection Group (SPG).

Geographically this force provides the most elaborate and organised setting for mainstreaming HIV among uniformed personnel through its field units' network, which is spread across the country in both urban and rural settings – through a large network of police zones, police ranges, police districts, police stations and police posts.

Police personnel deal regularly with high risk groups and vulnerable populations when latter come face to face with law enforcement agencies. Violence or insensitive handling of high risk groups (sex workers, drug users, MSM and transgender) and vulnerable populations such as truck drivers, migrants, marginalises them further and makes them more vulnerable to HIV. High-risk individuals who fear public exposure are harder to reach with HIV interventions. Thus, prevention efforts are weakened due to marginalisation and prejudice against the most-at-risk population groups. A sensitised, humane police force has a major role in supporting the creation of an enabling environment for targeted HIV prevention, care and support interventions among key affected populations. Within a hierarchical order, disciplined lifestyles and large audience in an organised setting, there is a unique opportunity for incorporating HIV prevention among the uniformed personnel. Since it is responsible for maintaining law

and order, the police force also becomes a potentially strong role model for positive behaviour.

Indian Police Force

Uniformed personnel all over the world are more vulnerable to HIV because of their age (youth is at the centre of the epidemic, globally and nationally) because they stay away from their families for long durations and because they are mobile and exposed to emotionally and physically tough situations with low access to health services.

Combating HIV/AIDS in the uniformed services is not a moral issue but a question of achieving maximum effectiveness. HIV/AIDS impairs readiness, valuable experience and skills are lost, a shortage of officers and troops may result, and less experienced personnel may have to take on more responsibility. Raising awareness of HIV/AIDS and encouraging behavioural change among members of the uniformed services will save lives and improve effectiveness. If left unchecked, HIV/AIDS can impact on the readiness of personnel and compromise national and internal security. Mortality and morbidity can reduce total troop strength, deployment strength and the recruitment pool for enlisted personnel.

Attrition in personnel not only creates a loss of continuity of command but increases the costs of recruiting and training replacements. The increased healthcare costs alone can be substantial, including costs for additional healthcare staff, medical insurance, life insurance premiums and disability payments. Absenteeism increases and productivity decreases as more people infected with HIV become ill.

Integration of HIV/AIDS in police training: Regular and adequate training of police personnel at all levels is necessary to upgrade professional skills. Induction and refresher training programmes also provide opportunities for building up their social sensitivity in accordance with changing needs and social paradigms. The MoHA has police academies for training senior police officers and police personnel.

Besides these, there are 215 state/UT and 69 Central Training Institutes in the country. These training institutes provide basic training to new recruits, in-service training to working police personnel and

⁵ Data on police organisations in India as on January 1, 2012, by Bureau of Police Research and Development, New Delhi.

specialised and state-of-the-art training to special task forces, special investigation squads, commandos, etc. Information about HIV/AIDS can be integrated in the training curriculum of these institutions.

Central Armed Police Force (CAPF)

The CAPF has eight 'common training centres' (CTCs), which impart training as per training syllabus to all CT/SO/officers. 'Welfare centres' impart training to the troops and family members. The welfare centres need to include awareness generation and training for prevention of STI/HIV, as well as install condom vending machines at strategic points. Staff nurses/para-medical staff and pharmacists need to be trained regarding counselling and testing. Advanced/special training could be given to doctors on management/treatment of HIV/AIDS. There are 180 ICTC centres with RDK facilities in CAPFs, 40 centres with Elisa Reader facilities, 38 composite hospitals, linkages with ICTC centres located throughout the country for diagnostic and counselling purposes; links to ART centres for treatment access has been established. Internally, four ART centres have been established to provide treatment and follow-up treatment for HIV/AIDS cases.

Under the action plan, the following steps have been taken by CAPFs for prevention of HIV/AIDS:

- a. Various programmes/measures are being adopted regularly and periodically in all CAPFs to create awareness among CAPF personnel and their families. Pamphlets, leaflets and booklets on HIV/AIDS have been published and disseminated. Regular training is imparted to the troops and their family members through welfare centres. HIV and AIDS information has been included in the basic training syllabus of CT/SO/officers.
- b. Within the Eight CTCs, several training programmes are conducted for imparting information for prevention of, and for awareness generation on, HIV. Special advanced/ training is imparted to the doctors on management/treatment of HIV/AIDS. Counsellors are trained to impart training in HIV counselling to staff nurses/para-medical staff and pharmacists. Nearly 180 ICTC centres have been established with RDK facilities in CAPFs.
- c. Treatment and other services: Currently, 40 centres with Elisa Reader facilities, 38 composite hospitals, linkages with ICTC centres located throughout the country for diagnostic and counselling purposes, linkages to ART centres for treatment access have been established. Internally, four ART centres have been established to provide treatment and follow-

up treatment to cases of HIV/AIDS. Nearly 1,262 condom vending machines have also been installed in various CAPF locations.

Mainstreaming HIV in prisons

HIV prevalence in prisons is considered to be higher than among the general population, which may be due to the factors that contribute to its spread: overcrowding, unsafe sexual activities, including MSM, IDUs, rivalry and fights between gangs, harassment including sexual harassment of younger inmates, and poor prison health services. People in prison settings may have alcohol or other substance-related problems. All these factors create an environment that increases the vulnerability of prisoners to sexually transmitted infections, tuberculosis and HIV infection.

India has a country-wide network 1,382 prisons: 123 central jails, 333 district jails, 809 sub jails and 19 women jails. The other forms of correctional institutions are open jails (44), Borstal schools (21), special jails (30), and other jails (3). The number of jail inmates (as on December 31, 2011) was 372,926: there are 356,902 men (95.7 per cent), and 16,024 women (4.3 per cent).⁶

Prison environments are greatly influenced by prison administrations – the latter have the responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV among prisoners and staff alike. As a matter of principle, 'all prisoners have the right to receive healthcare, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality'.

The formalisation of a partnership with the Ministry will ensure:

- Prison welfare officers/services in prisons support risk reduction activities, including providing information on prevention of STI/HIV/AIDS.
- HIV/AIDS is included in the induction trainings and refresher training of all cadres of staff in the prisons' services.
- All medical staff including doctors, staff nurses/ para-medical staff and pharmacists are trained on counselling, testing as well as on providing care, support and treatment to PLHIV as per national treatment protocols and guidelines.
- All health services in prisons provide counselling and testing services of PPTCT/STI/HIV as per national protocols and guidelines and provide referral linkages, wherever necessary.

⁶ Source: Prison Statistics, 2011, by National Crime Record Bureau.

11. Ministry of Defence

The Ministry of Defence is entrusted with the responsibility of the defence of the country. The Armed Forces Medical Services (AFMS), consisting of the Army Medical Corps (AMC), the Army Dental Corps (ADC) and the Military Nursing Services (MNS) provide comprehensive healthcare to the serving Armed Forces personnel, their families and dependants. In addition, ex-servicemen and their families are also entitled to free treatment from services sources as per rules and so are para military organisations such as Assam Rifles, Rashtriya Rifles, Coast Guard, the DRDO and Border Road Organisation personnel, while on posting in the field.

The uniformed services, especially young men and women, are highly vulnerable to HIV/AIDS because of their work environment, mobility, age and other factors – all of which expose them to a higher risk of infection than their civilian counterparts. The key factors associated with the defence forces, that is, their youth, difficult service conditions, prolonged separation from spouses and migrant nature of work all pose a higher risk of HIV infection. The Ministry of Defence intends to also focus on issues related to men having sex with men.

Combating HIV/AIDS in the uniformed services is not a moral issue but a question of achieving maximum effectiveness. HIV/AIDS impairs readiness, valuable experience and skills are lost, a shortage of officers and troops may result, and less experienced personnel may

have to take on more responsibility. Raising awareness of HIV/AIDS and encouraging behavioural change among members of the uniformed services will save lives and improve effectiveness. If left unchecked, HIV/AIDS can impact on the readiness of personnel and compromise national and internal security. Mortality and morbidity can reduce total troop strength, deployment strength and the recruitment pool for enlisted personnel.

The actions of uniformed service personnel can also have an impact outside their own ranks. HIV/AIDS tends to be more prevalent in countries during times of instability. Personnel stationed overseas as peacekeepers or who are a part of a military force can become infected and bring the virus back with them to their own country, where infection may be less prevalent.

To contain its spread in the Indian army, armed forces medical services have implemented a comprehensive HIV/AIDS control system that provides integrated, preventive, and curative services for its troops. The measures include policy formulations, IEC activities, surveillance, training, coordination and research. These efforts are aimed to bring about behavioural changes to prevent HIV infection at the individual level, as well as to build capacity at the macro level to deal with the multifaceted challenges of HIV/AIDS. As an outcome of these strategies, the Indian army has managed to keep the prevalence of the infection at a low level among its



personnel. The number of persons infected with HIV has declined significantly. The Indian army has also issued 'Guidelines for Management and Prevention of HIV/AIDS Infection in the Armed Forces' in 2003, which was later revised in 2010. As per the guidelines, the AFMC provides PPTCT and ART services to all troops and family members who are identified as being HIV positive. They have set up immunodeficiency centres for providing counselling and testing services in the clinics and hospitals of the defence forces, wherever required. As part of scaling up services of antiretroviral therapy to people living with HIV/AIDS, the DAC started an ART centre at the AFMC. This centre has been functional since January 2009 and is a first of its kind initiative. It is exclusively for civilians. It provides free drugs, counselling facilities, care and support services and state-of-the-art laboratory facilities. The centre is run strictly according to the operational guidelines of the DAC. The research division of the AFMS has undertaken many research projects on HIV and AIDS.

The AFMS is the largest and amongst the best organised health care delivery systems in the country. The health infrastructure of AFMS comprises 130 hospitals of varying sizes and facilities spread over the length and breadth of the country, the peripheral hospitals have basic specialist facilities, the eight Command/Army Hospitals have super specialist centres with state-of-the-art equipment and facilities. ICTC/PPTCT/STI services need to be incorporated, which would help to disseminate information on HIV/AIDS, promote voluntary counselling and HIV testing, syndromic management of STIs and prevention of parent-to-child transmission.

The Ministry of Defence has agreed to collaborate with the DAC to ensure:

- Inclusion of HIV/AIDS education programmes in all armed forces units, and among the dependant population of wives, children and parents and ex-servicemen
- Strengthening HIV/AIDS services in the AFMS, which is among the largest and best organised health care delivery systems in the country. The health infrastructure of AFMS comprises 130 hospitals of varying sizes and facilities spread over the length and breadth of the country. While the peripheral hospitals have basic specialist facilities, the eight Command/Army Hospitals have super specialist centres with state-of-the-art equipment and facilities. The services on ICTC/PPTCT/STI need to be incorporated, which would help disseminate information on HIV/AIDS, promote voluntary counselling and HIV testing, syndromic management of STIs and prevention of parent-to-child transmission.
- Reduce stigma and discrimination against people infected and affected with HIV/AIDS.

12. Ministry of Railways

The Indian Railways network contains 115,000 km of track over a route of 65,000 km with 7,500 railway stations. The Indian Railways has over 59,713 passenger coaches, 229,381 freight wagons and 9,213 locomotives. It runs almost 10,000 trains daily and has its own locomotive and coach production facilities. It is the world's fourth-largest commercial employer with over 1.4 million employees. Apart from regular employees, the Railways has to deal with thousands of other workers engaged as supply-chain workers, vendors, porters, cleaners, suppliers, etc. Approximately 16 million passengers travel daily, including migrant populations who travel by train to their work destination and home. The Ministry of Railways is one of the world's largest railway networks with millions on its workforce and a huge health infrastructure, while being the biggest service provider to millions of passengers in transportation.

The Railways' health infrastructure consists of 125 hospitals including nine zonal hospitals, five super specialty centres and nearly 586 health units with more than 13,700 indoor beds. It has 2,506 medical officers and 54,337 para-medical staff. The Indian Railways has a well-established Health Directorate divided into 16 zonal railways. Each zone has an administrative control for health services with a Chief Medical Director (CMD). The Ministry has been involved in improving access to HIV treatment and care services as well risk reduction services. Some activities undertaken by the Ministry to mainstream HIV are:

- **Red Ribbon Express project:** This unique project is the largest social mobilisation effort in the world, where a special train runs across the country with provision of HIV information, and counselling and testing services. Three phases of this project have been supported by the Indian Railways.
- **Provision of services to employees:** Provision of HIV testing, CD-4/CD-8 count testing and ART to eligible PLHIVs in railway hospitals, as well as counselling, testing and free distribution of condoms.
- **Monitoring HIV in railway employees:** Conducting annual sentinel survey to monitor trends of infection in people connected with the Railways.
- **Travel Support to PLHIV:** 50 per cent travel concession is provided in second class fare in trains for PLHIV to visit ART centres.
- **Services for railway medical employees:** Training to gazetted and non-gazetted employees of medical department of the Railways and provision of post-exposure prophylaxis to healthcare personnel of the Railways.



It is very crucial that the migrant population, passengers travelling by trains, has access to information regarding STI/HIV/AIDS prevention and services before they reach their destination. The passengers travelling in the train are in transit – trains provide a great opportunity to reach large numbers of people with information regarding HIV prevention and other services. In addition, significant numbers of people are directly and indirectly linked with the Railways, working as porters, suppliers, vendors, cleaners, etc. It cannot be ignored that populations that are most at risk of contracting HIV are also found in the vicinity of railway platforms.

Ignoring this would amplify the possible vulnerability and threat of spread of HIV infection. The lack of awareness, difficult work situations, limited accessibility to preventive services, inadequate mechanisms to effectively address HIV/AIDS issues as well as minimal preventive initiatives in and around railways stations can make the situation serious.

The collaboration between the Ministry of Railways and the DAC will be a great achievement within the national efforts towards HIV prevention and support to people affected and infected with HIV and AIDS.

13. Ministry of Shipping

India is a major maritime nation because of its long coastline of around 7,517 km. The Ministry of Shipping has 12 major and 200 non-major ports strategically located on the world's shipping routes. The 12 major ports are administered by the central government under the Ministry of Shipping and the minor ports are administered by the nine maritime states and three UTs within their respective coastlines. Nearly all the major ports in India are involved in CSR programmes which encompass health, education, employment, income and quality of life. The population living around ports and shipyards is dependent on fishing, shipping, ship breaking and other associated trades. They belong to groups vulnerable to HIV and AIDS. Most of them are migrants from adjoining or distant areas – including both single men involved in fishing and sailing and also single unmarried girls involved in cutting, cleaning and packaging of sea products. Ports are also the destination places of truck drivers, their helpers and porters, who bring in goods from all parts of the country for loading and unloading.

The Ministry of Shipping has signed an MoU with the DAC to provide HIV/AIDS/STI preventive services; care, support and treatment services to port workers as well as the community living around major ports including fishermen, seafarers, truckers, single male migrants and other vulnerable populations, etc; a stigma-free environment; and promote greater involvement of People Living with HIV (GIPA) in all major port areas. A joint working group has been formed for planning and implementing the activities.

14. Ministry of Power

The Ministry of Power is responsible for the development of electrical energy in the country. It is concerned with perspective planning, policy formulation, processing of projects for investment decision, monitoring and implementation of power projects, training and manpower development and the administration and enactment of legislation with regard to thermal, hydro power generation, transmission and distribution. The Ministry has six PSUs and two joint venture corporations under its administrative control. It handles several dam projects and employs several thousands of migrant workers. Need for risk reduction services are high at most dam sites. With its large workforce (including contract migrant workers) within PSUs and dam projects, the need for integrating HIV/AIDS in the Ministry's communication, training and health services is critical.

Due to remote location of power projects, all the PSUs under the Ministry of Power provide standard and effective medical facilities to its employees through their own health infrastructure. These medical services, in terms of health infrastructure and manpower, are useful resources to promote HIV prevention and provide care and support to the affected. All the PSUs focus on welfare activities for the employees and their families to create a sense of belonging and involvement in work. Priority is given by the management to provide housing, medical, educational facilities, etc. Awareness generation and communication activities for preventing the spread of HIV/AIDS can be undertaken under these welfare activities. As per the revised guidelines for CSR, all the PSUs allocate funds for CSR that can be used for prevention activities and social protection of those infected and affected by HIV.

The NTPC has 12 hospitals at its project sites through which subsidised medical facilities are provided to surrounding communities at project/station hospitals. Mobile ambulance facilities are run by the hospitals. Many activities/events – mobile health clinics, health camps and free operations, family planning programmes, de-addiction camps/programmes – are regularly undertaken in the neighborhood. Directly observed treatment-cum-designated microscopy centres (DOTs cum DMC) through NTPC Foundation have been serving and empowering the physically challenged and economically weaker sections of society. Under the NTPC Foundation, the Revised National Tuberculosis Control Programme (RNCTP) registered about 23,000 patients and provides treatment to more than 2,400 patients. The NTPC is a founder member of the UN Global Compact Society.

15. Ministry of Petroleum and Natural Gas

The Ministry of Petroleum and Natural Gas is entrusted with the responsibility of exploration and production of oil and natural gas, their refining, distribution and marketing, import, export, and conversation of petroleum products and liquefied natural gas. India is the fifth-largest energy consumer in the world, with oil and gas accounting for 45 per cent of the country's energy needs.⁷ In the Asia-Pacific region, India is the fourth-largest oil consumer and is fast emerging as the focal point for the future development of the Asian natural gas market. India is, and may remain, heavily dependent on coal for about half of its primary commercial energy requirements with the other half being dominated by oil and gas put together. Most of the incremental demand in the projected global oil consumption is expected to emanate from developing countries including India where oil consumption is expected to grow at the rate of 2.4 per cent as against the world average of 1.4 per cent⁸. It has 14 PSUs and subsidiary organisations, among which are includes several Central Public Sector Enterprises (CPSEs) enlisted as Maharatna, Navratna and Miniratna CPSEs. Under the ambit of CSR, each CPSE has to make a budgetary allocation for CSR and sustainability activities/projects

for the year. Through the proactive approach of CSR, many public and private sector enterprises under the Ministry of Petroleum and Natural Gas have made a significant effort to strive for the socio-economic development of the plant/project surrounding areas.

The Ministry of Petroleum and Natural Gas has signed an MoU with the DAC to achieve the following objectives:

- Reach all contractual workers/migrant workers in labour colonies and work sites with information on HIV/AIDS prevention and services through IEC activities.
- Enhance coverage and reach by information on STI/HIV through integration in Human Resource Training to all staff under the Ministry as well as to the large number of employees in all PSUs.
- Provide STI/HIV package of services on ICTC/PPTCT/STI/HIV through integrating them into the existing health infrastructure of PSUs.
- Undertake STI/HIV specific initiatives/projects through its health/medical care through the CSR activities of the PSUs.



⁷ Report by Ernst & Young: HR Challenges in the Indian Oil and Gas Sector; Petrotech 2010.

⁸ Report of the Working Group on Petroleum and Natural Gas sector for the 11th Plan (2007–12), MoP&NG.

16. Ministry of Coal

The Ministry of Coal has the overall responsibility of determining policies and strategies in respect to exploration and development of coal and lignite reserves, sanctioning of important projects of high value and for deciding all related issues. Coal is the most important and abundant fossil fuel in India. It accounts for 55 per cent of the country's energy needs. Under the administrative control of the Ministry, there are two major public sector undertakings and seven subsidiary units. The Ministry of Coal has a huge workforce engaged in drilling, mining, grading, loading and transporting – the total manpower in CSUs is 4.5 lakh (CIL 374650, NLC 17867 and SCCL 66,754). Hard coal deposits spread over 27 major coalfields are located chiefly in Jharkhand, Odisha, Chhattisgarh, West Bengal, Madhya Pradesh, Andhra Pradesh, Maharashtra, Rajasthan and Gujarat. All these states have high migration rates. The latest findings from HIV Sentinel Surveillance (HSS) 2011 also clearly highlight the linkages of HIV with migration. All these states thus require focused efforts for HIV prevention and control.

Mining is dangerous and has high injury and mortality rates. The coalfields are situated in remote forest areas or near river basins. These places not only lack medical facilities but have very little civic amenities and other infrastructure. The health access of workers and their families in remote geographical areas is a matter of concern. The most common disease suffered by people due to the dust from the coal mines is tuberculosis. This would amplify the possible vulnerability to, and threat of spread of, the HIV infection. Since coalfields are in remote locations, all the PSUs under the Ministry of Coal have established their own medical services consisting of dispensaries, colliery hospitals and regional hospitals in the coal belt to provide standard and effective medical facilities at the doorstep of the employees. These medical services are useful resources in terms of health infrastructure and manpower. Most mining tasks, both manual and mechanical, are strenuous in nature and thus done by men only. As such, these places placed become very unsafe for the few women involved in mining. Women are employed in secondary activities such as cutting, sorting, quarrying, loading and unloading. Due to exposure of women to mine disasters and mine pollution as well as to the reduction in quality of life due to denial of access to food security and job security, the health and safety of women become a serious concern. Thus lack of awareness, difficult work situations and limited access to services and inadequate

mechanism to address the challenge at mining areas heighten the people's vulnerability to HIV/AIDS. The Ministry of Coal can contribute significantly towards limiting the spread of HIV and mitigate the impact of the epidemic through education and peer support, care, support and treatment, ensuring job security and rights and ensure social protection.

Coal India Ltd (CIL) and its subsidiaries extend medical facilities to its employees and their families through various medical establishments from the dispensary level to the level of central and apex hospitals in different parts of the coalfields. There are 85 hospitals with 5,806 beds, 424 dispensaries, 667 ambulances and 1,477 doctors, including specialists in CIL and its subsidiaries to provide medical services to the employees. Out of these, 65 hospitals provide ICTC services and four hospitals provide ART services. In addition, special emphasis has placed on occupational health, and HIV/AIDS awareness programmes for the employees and their families. There are 149 master trainers and 2,812 peer educators.

As per the revised guidelines, all PSUs allocate funds for CSR, which can be used for prevention activities and social protection of those infected and affected by HIV by reaching out to the large number of employees in all PSUs with information on HIV through integration in human resource training, reaching out to all contractual workers/migrant workers through risk reduction for migrant populations in labour colonies and work sites through communication and mid-media activities.

The Ministry of Coal has signed an MoU with the DAC to achieve the following objectives:

- Reach out to all contractual workers/migrant workers in labour colonies and work sites with information on HIV/AIDS prevention and services through IEC activities.
- Enhance coverage and reach regarding STI/HIV through integration in Human Resource Training to all staff under the Ministry as well as to employees in all PSUs.
- Provide STI/HIV package of services on ICTC/PPTCT/STI/HIV through integration in existing health infrastructure of PSUs.
- Undertake STI/HIV specific initiatives/projects among its health/medical care through the CSR activities of the PSUs.

17. Ministry of Steel

The Ministry of Steel is responsible for planning and development of the iron and steel industry, development of essential inputs such as iron ore, limestone, dolomite, manganese ore, chromites, ferro-alloys, sponge iron, etc, and other related functions. Geographically, the major steel projects are in eight states of (Chhattisgarh, West Bengal, Odisha, Bihar, Jharkhand, Karnataka, Tamil Nadu and Madhya Pradesh). All these states have high migration rates, which require focused efforts for prevention of HIV. India is the fourth-largest crude steel producer of steel in the world and is expected to become the second-largest producer of crude steel in the world by 2015. India also continues to maintain its lead position as the world's largest producer of direct reduced iron (DRI) or sponge iron. The steel sector contributes to nearly 2 per cent of the GDP and employs over 5 lakh people.⁹ The Ministry of Steel is working towards transforming India into a global leader in the steel sector and to enhance the Indian steel industry's position internationally.

The Ministry of Steel has 12 PSUs under its administrative control and employs nearly 5 lakh people. Besides, PSUs constitute a large number informal workers including single male migrants and truck drivers. The iron and steel industry in the country (including re-rolling mills, alloy steel and ferro alloy industries, refractories) both in the public and private sectors.

The Steel Authority of India Limited (SAIL) is implementing preventive health programmes across all SAIL plants/units. It has adopted the HIV workplace policy and has been documented as a case study by the International Labour Organization.

This sector has both skilled workers and unskilled workers. Poorer and lower caste/tribe migrants tend to remain in low-paid unskilled jobs. The lack of awareness, difficult work situations and limited access to services and inadequate mechanism to address challenges in the mining areas heighten vulnerability to HIV/AIDS. The Ministry can contribute significantly towards

limiting the spread of HIV and mitigate the impact of the epidemic through education and peer support, offer care, support and treatment, ensuring job security and rights and ensure social protection.

All PSUs are engaged in outreach for community development activities. SAIL has adopted 79 villages as Model Steel Villages (MSVs) across eight states. Developmental activities being undertaken in these villages include medical and health services, education, road connectivity, sanitation, community centres, livelihood generation, sports facilities, health awareness and health camps, welfare activities, etc. There is scope to include communication activities for HIV/AIDS prevention.

All PSUs provide medical services through hospital networks. For example, SAIL has established 53 primary health centres, seven reproductive and child health centres, 18 hospitals and seven super specialty hospitals to provide specialised healthcare to the people; e-medical health centres for poor have been set up in Bhilai, Durgapur, Rourkela, Bokaro and Burnpur which provide free medical consultations, medicines, etc, to the peripheral population mainly comprising SC/ST and weaker sections of society. All other PSUs have similar health infrastructure. There is scope to integrate education about HIV/STI/AIDS in the health infrastructure under public sector undertakings.

Thus, the iron and steel industry, with its significant health infrastructure and manpower, can support the objectives of the DAC by:

- a) Enhancing coverage and reach of prevention services by information on STI/HIV prevention and services to its large workforce, especially migrants.
- b) Providing HIV/AIDS/STI related information and services through existing health infrastructure available in various public sector undertakings.
- c) Facilitating social protection for people infected and affected with HIV/AIDS.

⁹ Trends and Developments in Steel Sector - Year End Review 2012 - Major Achievements & Highlights of Ministry of Steel, Press Information Bureau, Government of India.

18. Ministry of Commerce and Industry

The Department of Commerce under the aegis of Ministry of Commerce and Industry (MoCI) is responsible for creating an enabling environment and infrastructure for accelerated growth of international trade. It has five statutory Commodity Boards among 10 autonomous bodies of Department of Commerce. They are: (a) Tea Board; (b) Coffee Board; (c) Rubber Board; (d) Spices Board; and (e) Tobacco Board – which are responsible for production, development and export of tea, coffee, rubber, spices and tobacco, respectively. Others are Marine Products Export Development Authority, Cochin; Agricultural and Processed Food Products Export Development Authority, New Delhi; Export Inspection Council, New Delhi; Indian Institute of Foreign Trade, New Delhi; and Indian Institute of Packaging, Mumbai.

PSUs and the Commodity Boards have both skilled and unskilled workers under the Department of Commerce. There are formal and informal workers including single male migrants and truck drivers at the production and export level. Women also work mainly as unskilled workers. They are vulnerable to various health risks,

including STI/HIV. The collaboration of the Department of Commerce and DAC will support the national efforts of HIV prevention and providing care to people infected and affected by HIV/AIDS according to the following objectives:

- Issue directives for adoption of policy on HIV as per national policy on HIV/AIDS and work place in all the estates, plantation units and PSUs.
- Issue directives from Department of Commerce for supporting HIV/AIDS programme in all autonomous bodies including Commodity Board and PSUs.
- Integration of STI/HIV related counselling, testing and treatment services in all health facilities, estates, plantation units and PSUs.
- Inclusion of HIV/AIDS in the ongoing training programmes of workers at the estates and plantations under the Commodity Board, and PSUs.
- Impart information on STI/HIV prevention, counselling, care and support and treatment to all its employees including contractual and informal workers in all the estates and plantations under the Commodity Board, and PSUs.

19. Ministry of Labour and Employment

The Ministry of Labour and Employment (MoLE) is one of the oldest ministries of the GoI. This Ministry works for improving the working conditions and the quality of life of workers, regulating conditions of work and ensuring occupational health and safety of the labour force. Within its mandate, the Ministry also seeks to promote the welfare of, and provide social security to, the workers in both organised and unorganised sectors. The Ministry achieves this through enactment of various labour laws, which regulate terms and conditions of service and employment of workers. At present, there are close to 44 labour-related statutes enacted by the central government that deal with minimum wage, social security, accidents, formation of trade unions, etc. The Ministry has been engaged with the DAC for formulation of policies and risk reduction intervention in the 'world of work' for the prevention of HIV and AIDS.

The key efforts for HIV mainstreaming undertaken by the Ministry are as follows:

- In association with the ILO and DAC, MoLE has prepared a National Policy on HIV/AIDS in the World of Work 2012. The policy protects workers against discrimination in the workplace, assures confidentiality of their status and provides access to information and services related to HIV. The Ministry has already undertaken several steps towards implementation of this policy including the issuance of formal letters to different ministries and departments, conducting a national workshop to orient nodal officers of various departments, imparting training to states to facilitate the roll-out of the National Policy on HIV/AIDS and the World of Work.
- Since 2001, the MoLE had been implementing the project 'Prevention of HIV/AIDS in the World of Work – A Tripartite Response' with the financial assistance of the US Department of Labor. Through this project, the National Labour Institute has organised sensitisation training programmes for over 3,340 participants including labour administrators, health officials, trade union leaders, education officers, North East Social Partners and NGOs. The Central Board of Workers Education (CBWE) has integrated HIV/AIDS as part of the regular syllabus in its programmes and 263 education officers have been trained.
- The Ministry has provided training to 29 Assistance Commissioners in the National Academy for Research and Training for Social Security.
- The ESIC hospitals (145) and dispensaries (1,400) are equipped to provide HIV/AIDS counselling, testing and treatment.

- The V.V. Giri National Labour and Research Institute was established as a resource centre for HIV activities.
- The MoLE and ILO worked together for capacity building activities for the Central Board for Worker Education, representatives of various public and private sectors and trade unions.
- The International Labour Conference of the ILO, at its 99th session held in Geneva in June 2010, adopted the autonomous recommendation on "HIV/AIDS and World of Work". The Indian delegation led by the Union Minister strongly supported the adoption of the recommendations on HIV/AIDS and world of work.
- HIV/AIDS has been excluded from the exclusion list of Rashtriya Swasthya Bima Yojana to bring PLHIVs under its ambit.

Given the significant differences in labour market conditions across different regions, the size and nature of India's migration presents a number of challenges. There is increasing evidence and growing recognition regarding the role of migration/mobility in the spread of HIV infection¹⁰ in India. Migration complicates the HIV epidemic by creating living conditions that heighten engagement in risky environments and by providing a vehicle through which infection can move from high to low epidemic regions. Evidence from Sentinel Surveillance clearly substantiates this.

The MoLE, being the nodal ministry for the workplace, has immense opportunity for addressing HIV/AIDS through its policies and programmes. The Ministry also has many autonomous bodies and affiliated institutions which can contribute significantly to the NACP through mainstreaming HIV in their agenda, as suggested here.

- Inclusion of HIV/AIDS awareness programmes in the curriculum in all training throughout the country, for example, Director General Employment and Training (DGET).
- Capacity building and creation of a pool of resource persons for workplaces in unorganised sectors through the CBWE and V.V. Giri National Labour Institute (VVGNI).
- Integration of HIV/AIDS throughout the health infrastructure available through dispensaries and hospitals of ESIC in the health infrastructure (ESIC and labour welfare).
- Facilitating access of PLHIV to social security schemes, such as RSBY.
- Engagement with labour unions for contacting workforce in both organised and unorganised sector.

¹⁰ Saggurti, Niranjan et al. 2008. "HIV risk behaviors among contracted and non-contracted male migrant workers in India: Potential role of labour contractors and contractual systems in HIV prevention."

20. Ministry of Communications and Information Technology

Communication and information technology are two of the fastest growing sectors in the world and India is positioned uniquely in both the sectors in terms of opportunity for growth and resources. The Ministry of Communications and Information Technology (MoCIT) focuses on making India an IT super power. It has the potential to play a crucial role in IEC activities related to HIV/AIDS. The focus of IEC activities is on promoting safe behaviour, reducing stigma and discrimination and generating demand for HIV/AIDS services.

There are three key departments under the MoCIT:

1. Department of Electronics and Information Technology.
2. Department of Posts.
3. Department of Telecommunications.

Department of Electronics and Information Technology, is responsible for the multi-pronged strategy of creating e-infrastructure to facilitate and promote e-governance, promotion of the information technology enabled services (IT-ITeS) industry, providing support for creation of innovative Research and Development (R&D), building a knowledge network and securing India's cyber space.

The Common Services Centres (CSC) under the department are delivery points for the government, private and social sector services for the rural citizens of India, delivered at their doorstep. The CSC scheme is envisaged to be a bottom-up model for delivery of content, services, information and knowledge, which can allow like-minded public and private enterprises – through a collaborative framework – to integrate their goals of profit as well as social objectives, into a sustainable business model for achieving rapid socio-economic change in rural India. CSCs provide various government services to the people.

The National e-Governance Plan (NeGP) provides public services to the common man at affordable costs, promoting rural entrepreneurship. There are mentioned under core areas: e-Governance for providing e-infrastructure for delivery of e-services, e-Industry for promotion of electronics hardware manufacturing and IT-ITeS industry, e-Innovation/R&D for providing support for creation of 'Innovation Infrastructure' in emerging areas of technology, e-Education for providing support for development of e-Skills and Knowledge network, and e-Security for securing India's cyber space.

The IT-BPO market under the Department of Electronics and Information Technology is one of the key sectors of the Indian economy because of its economic impact and potential. The sector is responsible for significant employment opportunities in the economy. IT services exports continue to be the largest employer within the industry. The sector is responsible for enabling employment to an additional 8.9 million people in various associated sectors – catering, security, transportation, housekeeping, etc, many of whom belong to areas/small towns of India. The NeGD also shares information in Gram Panchayats so that DAC officials can make good use of such CSCs in the AIDS campaign.

Collaboration is under way between the NeGD and DAC to leverage the outreach programme of CSCs (out of a total of 96,411 operational CSCs, nearly 3,000 CSCs in 25 states are covered under the outreach scheme) as a platform to create awareness about HIV/AIDS at the village level. It can raise awareness for prevention of HIV/AIDS transmission from parent to child by propagating institutional delivery for pregnant women in rural areas. The Department has agreed to collaborate with the DAC for:

- Reaching large numbers of the general population and migrants through Community Service Centre employees with information and services on HIV and voluntary blood donation, and through activities on risk reduction.
- Building capacities of Community Service Centre employees regarding STI/HIV prevention and care services, which would support referral services of HIV counselling and testing.

Department of Post, has the largest postal network in the world with 154,822 post offices (as on March 31, 2012), of which 139,086 are in rural areas (89.83 per cent). On an average, a post office serves an area of 21.23 sq km and a population of 7,817 people. A total of 466,903 people are employed in the postal department, including gazetted, non-gazetted and contractual employee.

The core activity of the Department of Post is processing, transmission and delivery of mail. It includes sale of stamps, booking of registered articles, remittance of money through e-money orders, iMO, mobile to mobile money remittance, booking of parcels, recurring deposits and Savings Bank services. To meet

its social obligations, payments to beneficiaries of MGNREGA are also done through postal department.

Regular training programmes are organised for employees by six postal training centres across the country. The Department of Post has 51 medical dispensaries across 18 states for providing medical services to its employees.

A number of infections are reported from the remote and rural areas of the country; rural communities are comparatively disadvantaged in terms of accessibility of HIV/AIDS awareness and prevention activities. There are 263,467 Gramin Dak Sewaks who are directly attached to the rural community and are stakeholders in community activities.

Considering the large infrastructure that the postal department has in urban and rural settings and its coverage of a large section of society including migrant populations and their families, it is envisaged that messages regarding HIV/STI prevention and services can be disseminated at post offices through panels and hoardings. One-line messages on HIV along with a Red Ribbon can be printed on envelopes, post cards, Savings and RD pass books and Money Order forms. Messages on HIV prevention, care and services can be put on the letter boxes and mail motor vehicles of the Department of Post – thus reaching a large number of postal employees in all postal circles across the country with information and services on HIV through HIV workplace programmes. HIV awareness materials can be included in the induction/training of the employees, especially of Gram Dak Sewaks, for strengthening HIV response at grassroot level. STI/HIV services can be integrated in the existing health infrastructure of the postal department.

Gram Dak Sewaks are people from the community who work in the postal department in the village. They can be sensitised on HIV/AIDS related issues during induction/training programmes, as they are the major stakeholders in the rural community and will further strengthen national response to combat HIV and AIDS at a grassroot level. The collaboration of the Department of Post and DAC would support the wider coverage of general people for awareness generation

and improve access of HIV related services for people through postal medical dispensaries.

Department of Telecommunication is responsible for policy formulation, licensing, wireless spectrum management, administrative monitoring of PSUs, R&D, standardisation/validation of equipment, etc. The Department is also responsible for: granting licenses for various telecom services like Unified Access Service Internet and VSAT service; frequency management in the field of radio communication in close coordination with internal bodies; and enforcing wireless regulatory measures by monitoring wireless transmission of all users in the country.

The Indian Telecom market is one of the fastest growing markets in the world. With nearly a billion telephone connections, India has become the second-largest network in the world. It also has the second-largest wireless network in the world. The Department of Telecommunication is divided into several units (a) Controller of Communication Accounts; (b) National Institute of Communication Finance; (c) Wireless Planning and Coordination Wing; (d) Telecom Engineering Centre; (e) National Telecommunications; (f) Vigilance Telecom Monitoring Cell Institute for Policy Research; and (g) Centre for Development of Telematics (C-DOT). The Department has four PSUs: (a) BSNL – Bharat Sanchar Nigam Limited; (b) MTNL – Mahanagar Telephone Nigam Limited; (c) ITI – Indian Telephone Industries Limited; and (d) TCIL – Telecommunications Consultants India Limited. The DAC has proposed collaboration in the following areas to the Department of Telecommunication:

- Reaching a large number of telecom employees under different units and PSUs with information on STI/HIV prevention and care services through sensitisation programmes.
- Reaching the general population with messages on prevention and services for risk reduction.
- Integration of STI/HIV in existing health infrastructure of PSUs under Department of Telecom as per the guidelines of NACP.
- Adoption of workplace policy as per national policy guideline on HIV/AIDS and 'world of work' in all the units and PSUs of the Department.

21. Ministry of Tourism

The tourism industry in India is substantial and vibrant, and the country is fast becoming a major global destination. It contributes 6.23 per cent to the national gross domestic product and 8.78 per cent of the total employment in India. Almost 20 million people are now working in India's tourism industry. The political and economic changes brought by the rapid growth of this industry have been a reason why young men and women are migrating from rural villages to tourist areas in search of work. The changes in the local distribution of labour – including a marked decline in the traditional rural agricultural economy and consistent growth in the informal sector and service work – have also led many people to migrate to tourist areas in search of economic opportunities. Tourism areas are, broadly, regions that are characterised by a high concentration of tourists, a wide range of tourism-oriented businesses (such as hotels, resorts, bars, restaurants, shops and discos), and a vibrant market for local service workers who provide the labour for these businesses or engage in informal tourism entrepreneurship. The fact that men and women participate in a range of tourism jobs – such as working in hotels, driving taxis, tour guide services and housekeeping – speaks of the fluidity of informal income-generation activities in tourism areas.

Tourism areas are epicentres of demographic and social changes linked to HIV risk, such as transactional sex, elevated alcohol and substance use and internal migration. High HIV prevalence rates among sex workers, high rates of HIV risk behaviour in tourism areas, demographic changes resulting from labour migration, and alcohol and drug use in tourism areas result in a heightened vulnerability to those directly involved and to the communities at large. Sex work establishments frequently cluster in and around tourism areas; the risk associated with each act of unprotected sex is likely to be higher in tourist areas.

The Ministry of Tourism functions as the nodal agency for the development of tourism in the country and formulation of national policies and programmes. It plays a crucial role in coordinating and supplementing the efforts of the state/UT governments, catalysing private investment, strengthening promotional and marketing efforts and in providing trained manpower resources for the development and promotion of tourism in the country.

In collaboration with the DAC, the Ministry has succeeded in mainstreaming HIV within its work. Some efforts of the Ministry in this direction are:

- HIV/AIDS training programmes organised for chefs, taxi drivers, dhaba owners and other workers in the unorganised sector (relating to the tourism sector) under the umbrella of capacity building of service providers (CBSP).
- Public awareness campaigns organised on HIV/AIDS through matches, games/plays at the Pushkar Mela.
- Information regarding HIV/AIDS disseminated to students and trainees through ITDC, NCHMCT, 26 IHMs, IITMs and NIWS, and 20 Tourist Offices (including five Regional Tourist Offices) in India.
- Four workshops organised on HIV/AIDS for heads of hotel management institutes in the northern and southern regions of the country, and for ministry officials.

Thus, there is need for sustained and committed action so that people who are vulnerable to HIV and those affected by HIV have access to information and services for prevention of STI/HIV, and work in a stigma- and discrimination-free environment.

22. Ministry of Information and Broadcasting

The Ministry of Information and Broadcasting (MoIB) is the nodal body responsible for supporting, controlling and guiding the audio, visual and print media in the country. Some of the important programme components of the MoIB include the Press Information Bureau, Department of Audio Visual Publicity, Song and Drama Division, Film Division, TV, Radio, Doordarshan, Prasar Bharati, Film and Mass Communication Institutions and Development of Communication Division.

The DAC's multiple programmes are implemented in partnership with the Ministry. These include folk media campaigns and campaigns through TV, radio and newspapers. For eight years, DAC-sponsored episodes were telecasted in 'Kalyani Health Magazine', a regular programme produced and telecasted by the DCD.

The MoIB, through mass communication media comprising radio, television, film, print media, advertising and traditional mode of communications like dance and drama, plays an effective role in communicating information. The Ministry is involved in not only catering to the entertainment needs of various age groups but also drawing the attention of the people to matters of national integrity, environmental protection, healthcare and family welfare, eradication of illiteracy and issues relating to women, children, minority and other disadvantaged sections of the society.

The Ministry works through six autonomous organizations: (a) Prasar Bharati includes All India Radio (AIR), Doordarshan and Community Radio; (b) Press Council of India; (c) Film and Television Institute of India; (d) Satyajit Ray Film and Television Institute; (e) Indian Institute of Mass Communication; and (f) Children's Film Society.

AIR, Doordarshan and Community Radio have the widest network coverage in India, most importantly in rural areas. As India's national broadcasters and also the premier public service broadcasters, they have been informing, educating and entertaining the masses since



their inception. They are one of the largest broadcasting organisations in terms of the number of languages of broadcast and the spectrum of socio-economic and cultural diversity they serve, reaching nearly 92 per cent of the country's area and 99 per cent of the total population. Considering the reach of AIR, Doordarshan and Community Radio, it is imperative that they provide information on prevention and services regarding HIV.

23. Ministry of Development of North East Region

Nearly 98 per cent of the North eastern (NE) region's border is bounded by India's international neighbours which, in spite of the government's best efforts, are porous, giving rise to problems of drug trafficking and human trafficking which exacerbates vulnerability to HIV/AIDS. The HIV epidemic in the NE region of the country is largely driven by use of HIV-infected syringes and needles by IDUs in some states and increasing transmission of HIV through sexual modes in the region.

The NE region has difficulties in terms of access, due to its hilly and mountainous terrain, which poses a great challenge to the delivery of health services. The health infrastructure is sparse and sketchy in remote and inaccessible areas; reaching pregnant women and high risk groups with appropriate services in these areas, thus, becomes very difficult.

Poor road connectivity, scattered habitations and low population density are the major reasons for lack of access to public health facilities in the NE Region. This lack of connectivity and lack of transport infrastructure poses special challenges for PLHIV, who face the double burden of treatment as well as travel expenses. Many PLHIV find it difficult to adhere to ART, which is very critical for the treatment regimen to be successful.

Ministry of Development of North East Region (MoDNER) is in the significant position of coordinating with different autonomous agencies in the region which cater to the region's economic development. MoDNER could spearhead the appropriate strategies to protect the vulnerable working population against HIV infection in coordination with autonomous organisations operating in the NE region, thus reaching a large population with information on STI/HIV/AIDS and related services; build capacity of functionaries in all departments to address HIV prevention and control activities in all the programmes and schemes of the respective departments; and extend social protection to people living with HIV/AIDS and affected family members through existing schemes.

24. Ministry of Textiles

The textile sector plays a pivotal role in the economy, contributing about 12 per cent of the manufacturing output and 11 per cent of merchandise exports. It employs about 45 million people. The unorganised sector is the major employer as compared with the organised sector, both in terms of the workforce and number of enterprises (12th Five Year Plan 2012–17, Vol 2).

The Ministry of Textiles is responsible for policy formulation, planning, development, export promotion and trade regulation of the textiles industry, including all natural and man-made cellulosic fibres that go into the making of textiles, clothing and handicrafts. The major sub-sectors that comprise the textiles sector include the organised cotton/man-made fibre textiles mill industry, the man-made fibre/filament yarn industry, the wool and woollen textiles industry, the sericulture and silk textiles industry, handlooms, handicrafts, the jute and jute textiles industry, and textiles exports. As per the latest Handloom Census of 2009–10, there are 23.77 lakh handlooms in the country, providing employment to 43.32 lakh handloom weavers and ancillary workers, which include 38.47 lakh adult handloom weavers and ancillary workers.

The major safety and health issues in the textile industry arise due to exposure to cotton dust, chemicals, noise and ergonomic issues. Exposure to cotton dust leads to respiratory disorders like byssinosis, commonly known as brown lung or pulmonary tuberculosis. Tuberculosis is one of the major opportunistic infections that makes workers especially susceptible to HIV/AIDS.

Women constitute nearly 77.9 per cent of handloom weavers/workers; division of tasks along gender lines positions them in lower order tasks. This makes them more exposed to the organic dusts of fibres and yarns, increasing their vulnerability to respiratory diseases as compared with men, and sometimes leading to higher risks of nasal or bladder cancer.

Nearly 47 per cent of all handloom weavers belong to families below the poverty line and 10 per cent fall in the Antyodaya Anna Yojana (AAY) category. A total of 27.83 lakh handloom households are engaged in weaving and allied activities, of which 87 per cent are located in rural areas. Poverty and illiteracy among weaver families is accompanied by poor access to basic necessities including health, thus increasing their vulnerability to HIV. Thus, the partnership with the Ministry will:

- Reach large numbers of unorganised textile workers and weavers with information and services for the prevention and control of HIV through the organizational structures of cooperatives.
- Improve access of pregnant women weavers and textile workers to PPTCT services to minimise the transmission of HIV to their children.
- Reach large numbers of organised textile workers with information and services for prevention and control of HIV, through the integration of this data in their health facilities.
- Integrate knowledge of prevention of STI/HIV/AIDS in all the training curricula meant for officials and textile workers.
- Include information on prevention of HIV/AIDS in the educational curriculum of all courses of textile engineering, fashion designing and weaving, etc.
- Ensure coverage of HIV related illness in all the insurance schemes of the Ministry.
- Adopt and implement 'National policy on HIV/AIDS and the World of Work' in the PSUs, autonomous institutes as well as public and private enterprises under the Ministry.
- Encourage skill building and employment of PLHIV and MARPs schemes of Ministry of Textiles.

25. Ministry of Road Transport And Highways (MoRT&H)

Road transport is critical infrastructure for economic development as well as social integration of a country. National and state highways form the economic backbone of the country and have often facilitated development along their routes; many new towns have sprung up along major highways. In India, road infrastructure is used to transport over 60 per cent of total goods and 85 per cent of total passenger traffic. India has one of the largest road networks –46.90 lakh km – consisting of national highways, expressways, state highways, major/smaller districts roads and village roads.

Transport can be considered as a social vector in the transmission of the disease, on par with other high risk behaviour such as injecting drug use and commercial sex which fuel the epidemic. Transport sector workers are more vulnerable to the HIV infection as workers in 'low-risk' occupations since they spend large amounts of time away from their families and can have multiple sexual partners. The recent HSS has revealed emerging pockets of infection among a bridge population. Besides high risk migrants, long distance truckers also show high levels of vulnerability and form an important part of the bridge population, since these groups serve as conduits of infection from HRGs to the general population, and play a significant role in the transmission of infection from areas with high prevalence to hitherto low infection areas.

The lack of awareness, transitory work situations, limited access to services and inadequate mechanisms to address the challenge heighten the vulnerability of transport workers to HIV/AIDS. Because of this bi-directional relationship, the Ministry of Road Transport and Highways (MoRT&H) can contribute significantly towards limiting the spread of HIV and mitigate the impact of the epidemic by dissemination information about prevention through education and peer support, offer care, support and treatment, ensure job security and rights and ensure social protection.

The Ministry is an apex organisation under the central government, entrusted with formulating and administering policies for road transport, national highways and transport research to increase the mobility and efficiency of the road transport system in



the country. It fulfills a major role in the Indian economy involving a wide array of industries and services which include vehicle manufacturers, equipment and suppliers, infrastructure builders, services, energy providers, public authorities, insurance and many others. Road transport, together with other modes of transport, provides indispensable mobility to persons and goods and contributes to the economic prosperity of a nation.

Road transport infrastructure is an important means for spreading awareness for prevention of HIV through facilitating the display of billboards or hoardings, etc, around bus stops, toll plazas, halting points, etc. The State Transport Corporation can have messages on bus panels. The Ministry can be an important partner of the National AIDS Control Programme in providing HIV preventive services designed to reduce the prevalence of HIV and other sexually transmitted infections among truck drivers and their sexual partners, including strategic behavioural communication, health education programmes, counselling and testing, service delivery and referral, and impact mitigation through travel support and employment.

The Ministry can also ensure that people living with HIV and those vulnerable to it are not discriminated during recruitment and at work. In addition, the Ministry can:

- Reach large numbers of transport employees and passengers with information and awareness about prevention of HIV.
- Reach large numbers of employees and transport workers with STI/HIV counselling and testing in existing health infrastructure and outreach mechanisms, such as mobile clinics.
- Include HIV/AIDS in the health insurance schemes planned and implemented for transports workers, truckers and their families.
- Make special provision for social protection, such as free travel, or travel at concessional rates, for PLHIV who travel for medical purposes.
- Ensure a stigma-free working environment for PLHIV and most-at-risk population in all the organisations under the Ministry's purview.
- Adopt the workplace policy and workplace programme as per national policy guidelines on HIV/AIDS and World of Work in all autonomous bodies and state road transport undertakings that come under the Ministry's ambit.

26. Ministry of Consumer Affairs and Food, Public Distribution

The primary policy objective of the Department of Food and Public Distribution is to ensure food security for the country through timely and efficient procurement and distribution of food grains. This involves procuring various food grains, building and maintaining food stocks and their storage, movement and delivery to the distributing agencies and monitoring of production, stock and price levels of food grains. The focus is on incentivising farmers by giving them a fair value for their produce by way of Minimum Support Price mechanisms, distribution of food grains to families living below poverty line (BPL) and covering poor households at the risk of hunger under the AAY, establishing grain banks in food-scarce areas and involvement of Panchayati Raj Institutions in the Public Distribution System. It undertakes the following schemes:

- OWS allocation and offtake details.
- Mid-day meal scheme.
- Wheat Based Nutrition Programme.
- Scheme for supply of food grains to welfare institutions.
- SC/ST/OBC hostels.
- Annapurna scheme.
- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)–‘SABLA’.
- Emergency feeding programme.
- Village grain banks scheme.

In June 1997, the GoI launched the Targeted Public Distribution System (TPDS) with a focus on the poor. Under the TPDS, states are required to formulate and implement fool-proof arrangements for identifying the poor for delivery and distribution of food grains in a transparent and accountable manner at the Fair Price Shop level.

To make the TPDS more focused and targeted at the ‘poorest of the poor’, the AAY was launched in December 2000 – for 1 crore of the ‘poorest of the poor’ families to be identified from the BPL families.

The identification of families under the AAY and the issue of distinctive ration cards to these

families is the responsibility of the concerned state governments. Guidelines were issued to the states/UTs for identification of families under the AAY, and additional Antyodaya families under the expanded AAY. It has been stressed that it is imperative to identify the ‘poorest of the poor’ from amongst the BPL families to be included in the AAY list. Allocation of food grains under the scheme is being made to the states/UTs on the basis that distinctive AAY ration cards are issued to the identified families.

The focus on the following priority groups has been enshrined in the scheme:

- (a) Landless agriculture labourers, marginal farmers, rural artisans/craftsmen (such as potters, tanners, weavers, blacksmiths, carpenters), slum dwellers, persons earning their livelihood on a daily basis in the informal sector (such as porters, coolies, rickshaw pullers, hand cart pullers, fruit and flower sellers, snake charmers, rag pickers, cobblers, destitute people) and other similar categories in both rural and urban areas.
- (b) Households headed by widows or terminally ill persons/disabled persons/persons aged 60 years or more with no assured means of subsistence or societal support.
- (c) Widows or terminally ill persons or disabled persons or persons aged 60 years or more, or single women or single men with no family or societal support or assured means of subsistence.
- (d) All primitive tribal households.

The above guidelines have been further amended as per a letter dated June 3, 2009, to include all eligible BPL families of HIV-positive persons in the AAY list on priority basis against the criteria mentioned in para 2(b) and 2(c) of the guidelines for identification of AAY families under AAY, circulated vide letter dated May 12, 2005, within respective ceilings on numbers of AAY families communicated by this Department.

Currently, 22 states are engaged in ensuring priority to the people living with HIV as per the directives.



VII. Conclusion

The HIV epidemic is a major public health problem in India with an enormous impact on human resources and the economy. Even though there is a decline in new HIV cases, sustaining the impact of current interventions and provision of continued care to people living with HIV would remain a major task.

The first generation of mainstreaming strategies that were employed include:

- Political will at the highest levels.
- Open discussion on the topic.

- Implementation of coordinated large-scale strategies, such as access to information, prevention programmes, condoms, counselling and treatment.
- Implementation of projects targeted at most-at-risk and vulnerable populations, which is fundamental to slow the advance of the epidemic.

For countries like India, with concentrated epidemics, second-generation mainstreaming actions may help continue the gains made in reduction of HIV cases. Successful HIV mainstreaming requires the optimal availability of human and non-human resources.

“Some of the key priority areas will be preventing new infections in hitherto low prevalence states while consolidating efforts in the high prevalence states.”

Prime Minister Dr Manmohan Singh at the Parliamentary Forum on HIV/AIDS, 2011

Chief among these are sufficient skills and capacity in the partnering ministry, private sector for strategic planning, financial planning and programme management skills, as well as the financial resources needed to bankroll multi-sectoral activities. There is also a need to optimise the functionality of inter-governmental planning and coordination. This will greatly assist in realising the effective joint planning and coordination between spheres that is essential in mainstreaming HIV.

Effective partnerships are one of the key determinants in successful HIV multi-sectoral efforts. This can be achieved provided:

- Sufficient political support is available to drive HIV multi-sectoral efforts.
- Structures of governance such as partnerships between civil society and municipalities are robust enough.
- Sectors work together to execute multi-sectoral HIV responses.



National AIDS Control Organisation

India's voice against AIDS

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