

India Report NCPI

NCPI Header

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Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::

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Describe the process used for NCPI data gathering and validation:

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

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

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

Organization	Names/Positions	Respondents to Part A
Department of AIDS Control	Dr. V. K. Subburaj, Secretary	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Shri K. B. Agarwal, Joint Secretary	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Ashok Kumar, Deputy Director General(BSD)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr.S.Venkatesh, Deputy Director General(M&E)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr.Sunil D. Khaparde, Deputy Director General(BTS & STI)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr. Neeraj Dhingra, Deputy Director General(TI)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Naresh Goel, Deputy Director General(Lab)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr A.S Rathore, Deputy Director General(CST)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Sh. A. S. Chauhan, Director (Finance)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Shobini Rajan, Assistant Director General(BTS & STI)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr B.B Rewari, NPO(ART)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Yujwal Raj, NPO(SI)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Raghu Ram Rao, NPO(ICTC)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Ms.Elizabeth Michael, Team Leader - Mainstreaming	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Sh. Gaurav Jain, Team Leader- Technical Support Group-Condom	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr Rajesh Kumar Rana, Account Director(Media)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Dr. Harprit Singh, NPO(BTS)	A1,A2,A3,A4,A5,A6
Department of AIDS Control	Mr Ugra Mohan Jha, Programme Officer(Statistics)	A1,A2,A3,A4,A5,A6

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

Organization	Names/Positions	Respondents to Part B
INP+	Abraham Kurian	B1,B2,B3,B4,B5
NCPI+	Daxa V. Patel	B1,B2,B3,B4,B5
NCPI+	Manoj Pardeshi	B1,B2,B3,B4,B5
PWN+	P. Kousalaya	B1,B2,B3,B4,B5
PWN+	Lalchhuanzuali	B1,B2,B3,B4,B5
INSW	Bharati Dey	B1,B2,B3,B4,B5
INSW	Bhagyalakshmi	B1,B2,B3,B4,B5
INFOSEM	Bindumadhav Khire	B1,B2,B3,B4,B5
INFOSEM	Taejha Singh	B1,B2,B3,B4,B5
TG Caucus	Laxminarayan Tripathi	B1,B2,B3,B4,B5
TG Caucus	K Sheethal	B1,B2,B3,B4,B5
Ashrey (Ashodaya)	Manjula Ramaiah	B1,B2,B3,B4,B5
Ashrey (Ashodaya)	Girija. M	B1,B2,B3,B4,B5
IHRN	Luke Samson	B1,B2,B3,B4,B5
IHRN	Bobby Singh	B1,B2,B3,B4,B5
IDUF	Umesh Sharma H.	B1,B2,B3,B4,B5
IDUF	Simon Wallington Beddoe	B1,B2,B3,B4,B5
UNODC	Kunal Kishore	B1,B2,B3,B4,B5
UNFPA	Anchita Patil	B1,B2,B3,B4,B5
UNESCO	Alisher Umarov	B1,B2,B3,B4,B5
UNODC	Abraham Lincoln	B1,B2,B3,B4,B5
UNDP	Ernest Noronha	B1,B2,B3,B4,B5
UNWomen	Norah Nyeko	B1,B2,B3,B4,B5
UNAIDS	Oussama Tawil	B1,B2,B3,B4,B5
UNAIDS	Nandini Kapoor Dhingra	B1,B2,B3,B4,B5
UNAIDS	Taoufik Bakkali	B1,B2,B3,B4,B5
UNAIDS	Nalini Chandra	B1,B2,B3,B4,B5

A.I Strategic plan

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

IF YES, what is the period covered: Five years

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: Key strategic approaches adopted during NACP-III(2007-2012) included 1. Effective use of evidence for planning, geo-prioritisation and decision-making 2. Addressing emerging challenges through flexible intervention modeling approaches 3. Designing for scale: Designing interventions and systems to enable effective nation-wide scale-up of services 4. Keeping communities at the centre: Community Involvement (HRGs, PLHIV) and Participatory approaches at all levels of programme planning, implementation and review 5. Evolving well laid out and standardized operational guidelines for every programme component covering all aspects of implementation 6. Setting up of 16 thematic Technical Resource Groups comprising of experts from diverse institutions and organizations advising the programme on policy decisions 7. Institutionalising quality assurance through strategic in-sourcing of technical support 8. Establishing robust structured mechanisms for capacity building, supervision and monitoring 9. Integrating with larger health system in a systematic manner and Mainstreaming HIV into other non-health ministries/ departments, industry and corporate sector. 10. Leveraging partnerships with civil society, development partners, academic institutions & private sector 11. Maintaining a balance between Prevention and Treatment 12. Mobilising political will Key Strategies under NACP-IV(2012-2017) include Strategy 1: Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population. Strategy 2: Increasing access and promoting comprehensive care, support and treatment Strategy 3: Expanding IEC services for (a) general population and (b) high risk groups with a focus on behaviour change and demand generation. Strategy 4: Building capacities at national, state, district and facility levels Strategy 5: Strengthening Strategic Information Management Systems

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: Department of AIDS Control is coordinating and delivering AIDS response in India. The multi-sectoral strategy is designed and implemented in collaboration and partnership with Ministries (listed under question 1); Development partners including multi-lateral, bilateral organisations and UN, and civil society engagement. Under this plan, 11 key ministries were identified for mainstreaming and partnership which include the Ministries of Human Resource Development, Home Affairs, Labour, Panchayati Raj, Railways, Shipping and Surface Transport, Rural development, Tourism, Women and Child Development, Youth Affairs and Sports, and Tribal Affairs , Ministry of Shipping, Department of Higher Education, Ministry of Coal, Department of Youth Affairs, Department of Sports, Ministry of Petroleum & Natural Gas and Ministry of Housing and Urban Poverty Alleviation. These aimed at risk reduction, improved access to service and social protection.

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

Education:

Included in Strategy: Yes

Earmarked Budget: Yes

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: Yes

Earmarked Budget: Yes

Military/Police:

Included in Strategy: Yes

Earmarked Budget: Yes

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: Yes

Transportation:

Included in Strategy: Yes

Earmarked Budget: Yes

Women:

Included in Strategy: Yes

Earmarked Budget: Yes

Young People:

Included in Strategy: Yes

Earmarked Budget: Yes

Other:

Included in Strategy: No

Earmarked Budget: No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: Yes

Elderly persons: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: No

People with disabilities: Yes

People who inject drugs: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: Yes

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: Yes

Human rights protection: Yes

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?:

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]:

: No

1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?: Yes

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

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?: Yes

b) Clear targets or milestones?: Yes

c) Detailed costs for each programmatic area?: Yes

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

e) A monitoring and evaluation framework?: Yes

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

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

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

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

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?: Yes, all partners

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: Yes

Sector-wide approach: N/A

Other [write in]:

: N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: Yes

HIV impact alleviation (including palliative care for adults and children): Yes

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

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

Reduction of stigma and discrimination: Yes

Treatment, care, and support (including social protection or other schemes): Yes

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

Other [write in]:

: N/A

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

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?: 4

4. Does the country have a plan to strengthen health systems?: Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Strengthening health systems - particularly HIV related infrastructure, logistics system, and human resource capacities - is in built to the national programme. NACO has also scaled up Opioid Substitution Therapy (OST) for Injecting Drug Users. This has been done in Public Health Settings and hospital staff have been trained on drug-related issues and treatment options. This has facilitated the linkage of targeted intervention sites to hospital settings. Joint guidelines & operating mechanism has been developed in close collaboration with National Rural Health Mission in the areas of STI, Care & Treatment, condom Promotion, blood safety & PPTCT. Through the findings

from the annual programme Joint Implementation Review Missions and programme evaluations conducted at the national and sub-national level, initiatives were undertaken for strengthening the HIV related infrastructure. With development partners, some of the key procurements for strengthening programme implementation infrastructure include CD4 count machines, blood bank equipments, test kits etc. Efforts were made for streamlining the Supply Chain Management (SCM) of various supplies to consuming units at the state and district levels and this includes training on SCM, placing Procurement and Logistics coordinators for groups of SACS etc. The National AIDS Programme has prioritised human resource capacity building for enhancing technical and managerial capabilities required for efficient programme implementation and planning. NACO with development partners has developed standardised curriculum, modules and tool kits. Innovative approaches were adopted for facilitating learning for example use of e-learning modules, video conferencing, e-group discussions etc.

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Many

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: Few

e) ART and Tuberculosis: Many

f) ART and general outpatient care: Many

g) ART and chronic Non-Communicable Diseases: Few

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

i) Other comments on HIV integration: : HIV integration is referred to by convergence and Mainstreaming. Convergence of HIV/AIDS services with the General Health system is a one of the major initiatives which Department of AIDS Control has taken-up. Counseling & Testing Services, HIV-TB collaboration, Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Infection (STI)/Reproductive Tract Infection (RTI), Condom Promotion, Opioid Substitution Therapy (OST) & Anti Retroviral Treatment (ART) are being identified for convergence with General Health Services. Mainstreaming HIV/AIDS is one of the most important strategies during National AIDS Control Phase-IV. Department of AIDS Control has already signed 8 MOUs with different Departments and Ministries of Govt. of India which includes Department of Higher Education, Department of Youth Affairs, Department of Sports, Ministry of Coal, Ministry of Defence, Ministry of Shipping, Ministry of Petroleum and Natural Gas, and Ministry of Housing and Urban Poverty Alleviation with the objective for spreading and supporting National AIDS Response. MoUs with others Ministries/Departments are under discussion. in pipeline. The Mainstreaming is one of the functions that has already been defined under objective 3- Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation and Function 6 - Information Education and Communication, and Social Mobilisation including mainstreaming.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?: 8

Since 2011, what have been key achievements in this area: Following are the key achievements since 2011: • There are 7 Regional Pediatric Centers and which are being upgraded to Centers of Excellence for care and support to infected children. • A draft policy framework for Orphaned and Vulnerable children has been developed but is yet to be endorsed. • There is a plan in place for children infected or affected by HIV being implemented in selected districts in high prevalence states by the India HIV/AIDS Alliance which is a Principal Recipient of the GFATM Round 6 grant for the country. • A few pilot projects focused on meeting the HIV related needs of orphans and vulnerable children are ongoing.

What challenges remain in this area: Key Concerns and Challenges for NACP-IV 1. Need to consolidate successes gained, by sustaining prevention focus besides effectively addressing the challenges 2. Given the experience of previous phases where the programme focused on saturating the coverage, NACP- IV needs to advance towards focusing on ensuring higher quality of services under interventions while sustaining the coverage. 3. Emerging Epidemics in certain low prevalence states and districts due to Migration to high prevalence areas, that is increasingly being identified as an important factor driving the epidemic in several north Indian districts, and epidemics related to IDU, MSM, TG & young sex workers 4. With increasing

coverage of treatment and decreasing AIDS-related mortality, a significant number of people are likely to require first and second line ART treatment during the 12th Plan period. Major challenge for the programme will be to ensure that the treatment requirements are fully met without sacrificing the needs of prevention 5. Regions with different maturity levels of the epidemic will require different resources and services. Emerging epidemics in selected regions will need greater prevention focus sustainability. Need to address the challenge of competing priorities and varying capacities of health systems in different states to provide access to quality HIV/ AIDS services 8. Ensuring social protection schemes for people infected and affected with HIV/AIDS through mainstreaming of HIV/AIDS with other ministries 9. Stigma and Discrimination that is still prevailing against the vulnerable population, persons and families infected and affected with HIV, especially at work place, healthcare settings and educational institutions. 10. NACP- IV has to address the need for innovation within all key programme strategies for integration of services, quality assurance at all service delivery points, coverage saturation, treatment adherence, data quality and use, etc.

A.II Political support and leadership

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

A. Government ministers: Yes

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

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: India's political leadership at the highest level, starting from India Prime Minister and notably including India Minister of Health and Family Welfare, undertook particular steps for keeping AIDS response high on the political and development agenda of the country; and committing to all its citizens continued effort for ensuring Universal Access to HIV prevention, treatment, and care and support services. During the launch of NACP-IV, Hon'ble Union Minister for Health & Family Welfare announced two major decisions that the Government of India has taken with respect to the ART Programme in India. Firstly, the eligibility for receiving ART has been revised from CD4 level of 350 to 500. This will ensure that HIV positive persons are initiated on treatment at an early stage; this will enhance their longevity and productivity as well as contribute to prevention of new infections. The second major decision that is the introduction of Third Line ART for all those who fail on second line ART under the programme. The Department of AIDS Control is working out the modalities for procurement of drugs and other system requirements to roll out Third Line ART at the earliest. Another major initiative announced by the Hon'ble HFM was the rolled out ART for all HIV positive pregnant women irrespective of CD4 count in the country from 1st January, 2014 by the Department of AIDS Control. The nation-wide roll out of this strategy will take us towards the goal of eliminating new HIV infections among children.

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

IF NO, briefly explain why not and how HIV programmes are being managed::

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

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?: Dr. Manmohan Singh, India Prime Minister is Chair person of the National Council on AIDS (NCA).

Have a defined membership?: Yes

IF YES, how many members?:

Include civil society representatives?: Yes

IF YES, how many?: 53

Include people living with HIV?: Yes

IF YES, how many?: 2

Include the private sector?: Yes

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

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

IF YES, briefly describe the main achievements:: The National Council on AIDS (NCA) is the apex body on HIV and AIDS in the country and is chaired by the Prime Minister of India. It therefore meets as necessary or in times of special need. DAC which is Indian equivalent of a National AIDS Commission is the secretariat of NCA. It manages donor coordination through a steering committee which meets regularly on a quarterly basis. Additionally, DAC regularly review actions on policy decisions, actively promotes policy decisions, and provides opportunity for civil society to influence decision-making. Example, active civil society engagement in NACP IV development. DAC is deeply engaged with approval of donor organisations' work plans. This is for harmonizing their activities with those carried out under budgetary sources of financing. As a result of these mechanisms, the following are established by DAC : 1. The Targeted Intervention programme working with MARPS is implemented by NGOs and CBOs. 2. Community and civil society groups were consulted and involved in development of training modules, guidelines and policies. 3. The private sector has been engaged in enhancing interventions for Migrants and Truckers. 4. Private sector representatives are part of working groups for future programme planning 5. Each area of National Programme has Technical Resource Groups (TRGs) that provides expert guidance to the programme. All TRG have civil society and community representation.

What challenges remain in this area::

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 35

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

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: Yes

Technical guidance: Yes

Other [write in]: 1. Involvement in NACP-IV planning, 2. M&E supporting in performance measurement 3. Advocacy 4. Planning commission review commission for HIV

: Yes

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

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

IF YES, name and describe how the policies / laws were amended: 1. HIV/AIDS tabled in parliament on 11th Feb, 2014; 2. Harm reduction Policy and 3. Work Place non-discrimination policy

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies::

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?: 8

Since 2011, what have been key achievements in this area:: The political support for the National Programme is high. At the July 2011 National Summit for Parliamentarians, Legislators, Zilla Parishad Chairpersons and Mayors on HIV/AIDS, the over 500 political leaders and representatives present pledged to sustain support for HIV/AIDS at National Convention. Thirdly, reaffirmation by the government of India to ensure that quality generic medicines, including antiretroviral (ARV) drugs, were seamlessly available in India and to all countries. The Joint Parliamentary Forum on AIDS at national level and State Legislative Forums on AIDS over a third of the states actively provide political support. It is envisioned that in future the politicians would set the agenda for HIV/AIDS and subsequently mobilize the public. In 2013, DAC, FPA, LFAs and State Governments executed two regional large-scale consultations that brought a gathering of elected representatives from different political parties with community representatives: one for the north-east region and one for the southern region of India in 2013. These Consultations were convened to engage Senior Political Leaders, Government Officials from Ministries, DAC, development partners and community representatives to share best practices, show case the existing social protection schemes and to identify key challenges in overall AIDS response. One of the major evidence of political commitments is the allocation of 63% of budget for NACP-IV from Domestic sources.

What challenges remain in this area::

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: Yes

Prison inmates: No

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

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

Yes

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws: The Constitution of India provides protection to all citizens—irrespective of age, gender, caste and class - to constitutional safeguards against discrimination. This covers PLHIV on matters of public employment and to some extent health care. Fundamental Rights enshrined in the Constitution of India are guaranteed to all citizens and form primary basis for protecting rights of people living with HIV and AIDS (PLHIV): Article 14 Equality before law , Article 15 Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth, Article 16 Equality of opportunity in matters of public employment , Article 21 Protection of life and personal liberty , Article 21A Right to Education India has non-discrimination laws for protecting rights and interests of women and children. These are through Articles 15 and 16 of the Indian Constitution and the Juvenile Justice Act.

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

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

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: No

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]:

: No

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

Briefly comment on how they pose barriers:

A.IV Prevention

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

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: Yes

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: No

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: Yes

Reduce the number of sexual partners: Yes

Use clean needles and syringes: Yes

Use condoms consistently: Yes

Other [write in]:

: No

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

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

2.1. Is HIV education part of the curriculum in:

Primary schools?: No

Secondary schools?: Yes

Teacher training?: Yes

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

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

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

Briefly describe the content of this policy or strategy: The Department of AIDS Control's communication strategy has moved from creating general awareness to Behaviour Change Communication. It aims to motivate behavioural change among most at risk populations, raise awareness and risk perception among general population, particularly youth and women, generate demand for HIV/AIDS related health services like condoms, ICTC/PPTCT facilities; and create an enabling environment that encourages HIV related prevention, care and support activities and to reduce stigma and discrimination at individual, community and institutional levels. The Department of AIDS Control implements integrated and comprehensive campaigns using 360° communication approach. Regular campaigns are conducted at national and state level using mass media, mid-media, outdoor, interpersonal communication, and innovative media vehicles like digital cinema, panels in metro trains, digital screens, internet, and mobile phones among others.

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

People who inject drugs: Condom promotion, Drug substitution therapy, HIV testing and counseling, Needle & syringe exchange, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Men who have sex with men: Condom promotion, Drug substitution therapy, HIV testing and counseling, Needle & syringe exchange, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Sex workers: Condom promotion, Drug substitution therapy, HIV testing and counseling, Needle & syringe exchange, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion, Drug substitution therapy, HIV testing and counseling, Needle & syringe exchange, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

Prison inmates: Condom promotion, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

Other populations [write in]:

:

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?: 8

Since 2011, what have been key achievements in this area: The policy efforts in support of HIV prevention have been critical to India's AIDS response. HIV prevention is a central strategy of India's NACP IV with specific focus given to the high risk groups of female sex workers, injecting drug users, men having sex with men and the bridge population groups of migrants and truckers. From the private sector, some organizations have come forward and are partnering with SACS such as in Gujarat to undertake migrant interventions through a public private partnership where SACS provides Technical Support inclusive of Capacity Building and materials required such as IEC and the organization caters to the migrant population in its geographical reach through its own human resource and initiatives. Similarly in Truckers intervention, while we have liaised with NGOs and Associations, Organizations in the industry have also stepped forth to adapt our approach in their workplace. Here too SACS partners in terms of Technical Support and in procurement initiatives such as in IEC, setting up of clinics and so on, followed by vulnerable population of women and youth. The assessment of the Targeted Intervention projects in India for HIV prevention point to its positive effect in preventing HIV acquisition and HIV transmission. Behaviour change communication with most at risk populations led to increased health seeking behaviour and increased access to testing and treatment services. The Department of AIDS Control's communication strategy has moved from creating general awareness to Behaviour Change Communication. The Department of AIDS Control implements integrated and comprehensive campaigns using 360° communication approach. Regular campaigns are conducted at national and state level using mass media, mid-media, outdoor, interpersonal communication, and innovative media vehicles like digital cinema, panels in metro trains, digital screens, internet, and mobile phones among others.

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

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

IF YES, how were these specific needs determined?: The strategy and plan for NACP-IV (2012-2017) has been developed through an elaborate and extensive process. The process has adopted an inclusive, participatory and widely consultative approach with 15 Working Groups and 30 sub-groups covering all thematic areas involving 624 representatives from central and state governments, representatives of high risk group communities, people living with HIV/AIDS, civil society, subject experts, experts from NHM and other government departments, development partners and other stakeholders. Regional and state level consultations, e-consultations and special studies/ assessments were also undertaken to develop the strategic plan. Planning commission steering committee has also been closely overseeing this entire process.

IF YES, what are these specific needs? :

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Agree

Condom promotion: Agree

Economic support e.g. cash transfers: Agree

Harm reduction for people who inject drugs: Agree

HIV prevention for out-of-school young people: N/A

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

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

Prevention for people living with HIV: Agree

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

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Agree

Reduction of gender based violence: Agree

School-based HIV education for young people: Agree

Treatment as prevention: Disagree

Universal precautions in health care settings: Agree

Other [write in]::

:

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 9

A.V Treatment, care and support

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

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

Briefly identify how HIV treatment, care and support services are being scaled-up?: As stated previously, The HIV Care, Support and Treatment services are updated and expanded continually based on the current requirements and feedback received through assessments and reviews. Effective oversight and guidance to the Care Support and Treatment programme

is provided by the Technical Resource Groups (TRG) at the national level with DAC. The TRGs comprised of a group of experts who reviewed progress in programme implementation, and provided technical inputs, suggestion and recommendations on various technical and or operational issues relating to the programme. Meetings of TRGs were held periodically with clearly drawn agenda and issues for discussion. Following were the TRGs inputting to the CST programme: (i) TRG on ART, (ii) TRG on Paediatric HIV, (iii) TRG on Community Care Centres, and (iv) National HIV drug resistance committee. TRG meetings were held at least once a year, if not earlier to address specific items. Under their oversight, effective delivery of the CST programme is enabled. • Care, Support & Treatment Programme provides prevention and treatment of opportunistic infections, Anti-Retroviral Therapy, psychosocial support, home based care, positive prevention and impact mitigation. During the last 3 years, there has been significant up scaling of Care, Support & Treatment activities in terms of the number of ART centres, number of patients registered and number of patients on-ART. Under the Care, Support and Treatment Programme, the number of Anti-Retroviral Therapy (ART) centres has been scaled up from 127 in 2007-08 to 420 in March 2014. In addition, there are 876 Link ART Centres. There are 7.34 lakh PLHIV on first line ART and 7500 PLHIV on second line ART treatment.

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

The majority of people in need have access to...:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Agree

Economic support: Agree

Family based care and support: Agree

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

HIV testing and counselling for people with TB: Agree

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

Nutritional care: Agree

Paediatric AIDS treatment: Agree

Palliative care for children and adults Palliative care for children and adults: Agree

Post-delivery ART provision to women: Agree

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

Post-exposure prophylaxis for occupational exposures to HIV: Agree

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

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Agree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]:

: Agree

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

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

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?: No

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

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

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 9

Since 2011, what have been key achievements in this area::

What challenges remain in this area::

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: No

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?: 8

Since 2011, what have been key achievements in this area::

What challenges remain in this area::

A.VI Monitoring and evaluation

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

Briefly describe any challenges in development or implementation:: Some of the key challenges in successful implementation of M&E system in India are: 1. Ensuring quality of data reported from around 20,000 reporting units across the country. 2. Adoption of standard definitions of monitoring indicators across all reporting units. 3. Enhancing use of data at state and district levels for decentralised programme planning and implementation. 4. Ensuring reporting from interventions implemented by partner agencies in uniform formats.

1.1. IF YES, years covered: 5 years

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

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

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: Yes

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

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

Guidelines on tools for data collection: Yes

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

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?: 3

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

Briefly describe any obstacles:-

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

In the Ministry of Health?: Yes

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

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Deputy Director General	Full-time	7 years

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
National Programme Officer	Full-time	8 years
Programme Officer (Statistics)	Full-time	5 years
Epidemiologist	Full-time	2 years
Programme Officer (Surveillance)	Full-time	2 years
Programme Officer (Biomedical and Clinical Research)	Full-time	3 years
Programme Officer (Evaluation and Operational Research)	Full-time	1 year
Programme Officer (M&E)	Full-time	1 year
Monitoring & Evaluation Officer	Full-time	1 year
Monitoring & Evaluation Officer	Full-time	1 year
Monitoring & Evaluation Officer	Full-time	Vacant
Monitoring & Evaluation Officer	Full-time	vacant
Monitoring & Evaluation Officer(Basic Service)	Full-time	1 year
Monitoring & Evaluation Officer(Care Support & Treatment)	Full-time	2 years
Technical Officer (R&D)	Full-time	4 years
Technical Officer (Surveillance)	Full-time	1 year
Technical Assistant	Full-time	6 years

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

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

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

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

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

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

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

IF YES, but only some of the above, which aspects does it include?:

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: Yes

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

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

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

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

IF YES, for which population groups?: General Population, High Risk Groups, Bridge Population

Briefly explain how this information is used::

(c) Is coverage monitored by geographical area?: No

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

Briefly explain how this information is used::

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

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]: Research and Advocacy

: No

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

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

At national level?: Yes

IF YES, what was the number trained:: 200

At subnational level?: Yes

IF YES, what was the number trained: 2000

At service delivery level including civil society?: No

IF YES, how many?: 10000

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: Data analysis, modelling and proposal writing

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 9

Since 2011, what have been key achievements in this area::

What challenges remain in this area::

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?: 3

Comments and examples:: • Civil society (CS) considers their level of engagement in policy formulation to be relatively reduced post-2012, but highlight the opportunity of reinvigorating it now that NACP-IV is formally launched. During NACP IV planning in 2011-12, a number of KP & PLHIV networks' representatives participated in the series of planning workshops organised at state / regional / national levels. There is a recommendation for joint collaboration between all partners to input to operational planning & discussion on program priorities, targets, budgets, etc. be reinforced. • Non-Governmental Organisations [NGO]/Community Based Organisations [CBO]) continue to actively contribute to program implementation particularly for HIV prevention through Targeted Intervention projects. HIV Community Support Centres are also to be implemented with their support. CS would like their involvement in programing to be scaled up. • There have been certain positive steps in the direction of creating an enabling legal environment as a result of efforts of KP, PLHIVs & other CS representatives. o Following a petition filed by NALSA & Transgender activists highlighting the multiple problems faced by the community, Supreme Court passed a judgement in April '14 granting Transgender the status of third gender. o HIV Bill includes provisions for securing legal protection for PLHIV & HIV affected people against discrimination, guarantee to free HIV & health treatment, social protection, etc. The Bill is introduced in Parliament. • Narcotic Drugs & Psychotropic Substance Act 1985 was amended in February '14. It includes changes that are supportive to securing health of PWID by legitimizing OST & other harm reduction services. But PWID can be arrested for consumption/or possession of small quantities of drugs. Amendment of this Act did not receive CS involvement. • A set-back to the community is the re-criminalization of adult consensual same-sex contacts.

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

Comments and examples: □ Civil society representatives were well involved in the planning process of the NACP IV, but not in the national budgeting or formulation of the NACP IV strategy document, as elaborated on below. • Representatives were engaged in meetings held at state and regional level (through consultations and e-discussion) and at national levels (series of thematic working group discussions) during 2011-12 as part of the planning process. At the time, thematic-based working groups had presented detailed reports to DAC and the Planning Commission, however, the expectation that they would receive feedback on the final national document that was being planned was not met. • Civil society’s engagement in discussions on budgeting was negligible asides from a limited discussion held during the working group meeting on men having sex with men with few civil society representatives present. The NACP IV strategy document, released in January 2014, was formulated without their involvement which had been expected by them. □ Civil society recognize the patronage that has been provided by the political leadership from the highest level to AIDS, and that around 63% of the total estimated resource envelope for NACP IV will be covered through domestic budgetary resources. Civil society representatives are keen and would like greater involvement to planning, programming and budgeting based on their relative knowledge, capacities and skills. Now that NACP IV is launched, there is opportunity to re-engage and strengthen collaboration as the operational plans and other supporting documents are developed. There is a recommendation for re-convening Technical Working Groups and / or other platforms to facilitate two-way dialogue on these critical areas at Centre and in all States.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 3

b. The national HIV budget?: 3

c. The national HIV reports?: 4

Comments and examples: • Civil society involvement in the national strategy: Civil Society representatives were part of the planning process for NACP IV. A group of civil society representatives fed into this process at various levels ranging from state level meetings to multiple regional meetings and meetings at the centre with DAC and a meeting with Planning Commission. Reports and feedback from the various meetings were presented to DAC and Planning Commission, and discussed further with civil society representatives. Furthermore, the individuals who had the opportunity to get involved in the planning process were (1) not representative of all the concerned communities (sub-groups), and (2) not all of those involved in the consultation had access to the draft strategy. • There has however been a certain level of discussion on HIV prevention interventions with key civil society partners. □ As NACP IV was launched in January 2014, there is now increasing anticipation by civil society towards concrete discussion on the operationalization of the NACP IV and towards achievement of ambitious targets. • Civil society involvement in the national budget: Government’s commitment to AIDS response was reflected through the decision to increase domestic budgetary resources for NACP IV—by around three to four times as compared with NACP III—which would be supplemented by budgetary support from external partners / donor organisations. However, the Civil Society involvement in the budgeting of the strategy remained very limited, despite some discussions involving some community representatives with the planning commission. • Civil society involvement in the national reports: Civil society provides periodic reports, as part of the set roster under the NACP by DAC and SACS. Reports from the service centre level are submitted on weekly basis using prescribed formats, which are amalgamated towards the monthly, quarterly and annual reports.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?: 1

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 1

c. Participate in using data for decision-making?: 1

Comments and examples: Civil society involvement in overall programme M&E is low or next to negligible. The role of Civil Society had remained limited to reporting on activities that they implement as part of the national response. Civil society would like stronger engagement with Government regarding the (1) design of the national programme's M&E plan, and (2) national M&E strategy. (3) Facilitating their knowledge on key information generation mechanisms is necessary as is presentation of certain analysis to enable greater understanding on the level of progress made and areas where further efforts need to be concentrated. (4) Civil society could play a greater role in qualitative monitoring.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

Comments and examples: • Civil society representation in HIV efforts is inclusive of diverse organizations. It has improved notably. Many more groups are represented in a more inclusive way. However, the level of civil society groups' engagement is in a way determined by the individual organizations' capacities. Should these capacities be further strengthened, the overall civil society contribution (and in terms of increased number of organisations) across India will be expanded. • Civil society participated in (1) planning for NACP IV and continued (2) playing an important role in implementing Targeted Interventions for HIV prevention and providing care and support to people living with HIV and key populations. Civil society also have played an active role in (3) advocacy initiatives at the national and grass root level, including towards creation of an enabling environment through positive legal provisions. There was a recognized need for developing closer coordination and networking amongst the civil society, and with partners including Government, so that they may play a stronger role in AIDS programming and implementation.

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

a. Adequate financial support to implement its HIV activities?: 3

b. Adequate technical support to implement its HIV activities?: 3

Comments and examples: Civil society receives both financial and technical support for implementing specific activities or projects under NACP. • Financial support: Civil society receives financial support at specific intervals and in the specific amounts, as per the plan documents. Post 2012, salaries have gone up and there is a general increase in overall funding. However, financial support is considered by Civil Society representatives as less than optimal especially for implementing certain interventions in geographically remote areas. There have been instances of essential commodities' stock-outs, for which the efficiency of the central procurement process and supply chain management needs to be enhanced for addressing such situations, should they arise. Nevertheless it affects the overall ability of civil society implementing activities or projects, to do so efficiently. • Technical support: National Technical Support Unit, state Technical Support Units and State Training Research Centres were instituted for providing technical support to civil society organisations and representatives implementing activities and projects. The nature and amount of support provided, however, can be further enhanced as it tends to be restricted to certain areas of work, such as filling in M&E reporting formats as part of the periodic reporting processes for example. Need for stronger technical support is recognised, especially for facilitating an improvement of capacity in organisations, etc. This is essential especially in areas where civil society organisations are at relatively nascent stages such as in northern India where the epidemic trends need stronger civil society organizations to contribute effectively to the response.

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

Prevention for key-populations:

People living with HIV: <25%

Men who have sex with men: >75%

People who inject drugs: >75%

Sex workers: >75%

Transgender people: >75%

Palliative care : <25%

Testing and Counselling: 25-50%

Know your Rights/ Legal services: >75%

Reduction of Stigma and Discrimination: >75%

Clinical services (ART/OI): <25%

Home-based care: <25%

Programmes for OVC: <25%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2013?: 6

Since 2011, what have been key achievements in this area: Civil society (CS) is a key partner in the AIDS response in India. They are engaged on specific areas of the program at varying degrees & at varying geographic levels. It is mainly centred towards supporting HIV prevention interventions, & provision of HIV related care & support. There is much scope to (1) increase the level of two-way engagement between CS & national partners: recognising the capacities & knowledge available within civil society organisations (CSO). By (2) supporting skill building among CSO, specifically at the decentralised level in specific states where their role is limited; the level & quality of their contribution can be enhanced further. Brief summary of key achievement are as follows: • CS was involved in the NACP IV planning process, via engagement of certain representatives in the series of working group discussions & meetings held at national & sub-national levels. • CS is key & active implementers of: o Targeted Intervention projects for HIV prevention among KP. o Providers of care & support to the community & KP, in support of national efforts. o Support interventions for behaviour change, disseminating information & messages on HIV prevention & risk reduction, helping to break the silence on HIV. • CS representatives participate in various discussion meetings organised periodically by certain partners on the programme & AIDS response, for varying purposes. Example: participation in the regional consultations with Parliamentarians for the North-east & Southern zone, Mid-term Review of the 2011 High Level Meeting Targets, consultations on social protection, on harm reduction, etc. • In most cases, CS is involved in the national Technical Resource Groups established for each program area. • Through CS advocacy & discussion with national partners, focus on the needs for harm reduction & specific requirements for each KP groups /sub-groups & PLHIV; social protection, etc. is coming to the fore

What challenges remain in this area: • Civil society would like improved coordination at the state and national levels and a greater involvement of PLHIV and key populations in all components of the program. • Their current engagement in programme Monitoring and Evaluation and activity budgeting is negligible and it is recommended that this be addressed • There is need to strengthen two-way engagement with other relevant Ministries, such as Ministry of Social Justice and Empowerment, Department of Health, etc.

B.II Political support and leadership

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

IF YES, describe some examples of when and how this has happened: • Involvement in Planning: Civil society (CS) including KP & PLHIV participated in the NACP IV planning process which had included a cascade of meetings from sub-national level upwards in 2011. Few representatives participated in national thematic meetings. Documentation emerging through this consultative process was presented to DAC & Planning Commission in 2012. Level of participation at the budget & strategy formulation stages, however, thinned out. □ With NACP IV's official launch in 2014, there is opportunity & anticipation to (1) reinforce operational & strategic planning processes to advance on ambitious targets & strengthen teamwork. (2) Platforms for comprehensive engagement to be activated (e.g. Technical Resource Groups); other platforms considered; etc. (3) Integration with Health & other Ministries is critical to address CS' various Health & support needs. • CS is actively involved in the

programming process. They are key implementers specifically for certain interventions. E.g HIV targeted intervention projects across India. They support HIV care & support efforts. □ With Government & partners, they played a key role in bringing attention to specific challenges affecting communities. E.g: highlighting the need for harm reduction among PWID, need for specific Transgender interventions & other groups, etc. • CS is actively supporting creation of a legal environment conducive to KP & PLHIV. Today Transgender are recognized as a Third Sex in India following landmark judgment delivered by Supreme Court (2014). Passage of the HIV Bill is now advancing in Parliament, & it is critical the momentum be maintained. A throwback to the community & sections of the larger CS was the surprise Supreme Court judgment (December 2013) which upheld the constitutional validity of Section 377 of the Indian Penal Code. Whilst recognizing the various initiatives, CS urge for their greater engagement & participation in policy making, programming & budgeting

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: Yes

Women and girls: Yes

Young women/young men: No

Other specific vulnerable subpopulations [write in]:

: No

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

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws: • India's Constitution guarantees Fundamental Rights to all citizens under Articles 14 (Equality before law), 15 (Prohibition of discrimination on grounds of religion, caste, sex etc.), 16 (Equality of opportunity in matters of public employment), 21 (Protection of life & personal liberty), & 21A (Right to Education) particularly. • Legislations for women include Dowry Prohibition Act (Sections 498A, 304B of the Indian Penal Code [IPC]), Hindu succession (Amendment) act 2005. □ Criminal Law (Amendment) Act 2013 provides for amendment to sections of the IPC; Indian Evidence Act; & Code of Criminal Procedure 1973 on laws related to sexual offences. Important changes include amendment of the Rape Law, new offenses added to the IPC. □ Safety net programs, entitlements for women & vulnerable populations include Widow Pension, Employment Guarantee Act, etc. None of the provisions were

considered satisfactory by women representatives in adequately empowering them to seek system-supported recourse to address grievances. • Legislations for children include (1) Juvenile Justice (Care & Protection of Children) Act, 2000 which provides for a special approach to prevent & treat juvenile delinquency & provides a framework for their protection, treatment & rehabilitation. Model Rules 2007 was added to improve effectiveness of this legislation. Several High Courts constituted Juvenile Justice Committees to address its implementation. (2) Right to Education 2010 provides free & compulsory education to every child (6-14 yrs.) & makes specific mention of children with disabilities/weaker/disadvantaged communities. • State specific protective policies for Transgender (TG) through Government Orders in Tamil Nadu (2009) & Karnataka. Maharashtra State's Women & Child policy for the 1st time includes 2 chapters dedicated to FSW & TG issues. Chhattisgarh & Delhi issued Orders on Labour cards for TG, formation of a TG welfare board; included TG in the AAY scheme & the poverty census

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

Briefly comment on the degree to which they are currently implemented: • Laws & policies exist, but enforcement an issue. • Civil society espouses the existing legal provisions as insufficient in adequately empowering them to seek system-supported recourse on account of their sero-status or even identity. As the country does not have a specific anti-discriminatory law for PLHIV which is a felt need, ensuring smooth passage of HIV Bill in Parliament is critical. • There are several barriers to accessing both, the judicial system & seeking support from law enforcement agencies or other service providers. This is on account two main factors: (1) There is a level of discriminatory attitude & behavior met out to KP & PLHIV by service providers/law enforcement agencies/& others. Discrimination can become either a deterrent for KP & PHIV from sustaining their interaction; Or they choose to withstand the discrimination though it causes personal hurt & confirms a sense of violation of one's rights; Or they opt to remain hidden. (2) Certain laws have a punitive effect of KP & PLHIVs' rights & counters the level of support that the judicial system, law enforcement agencies & others can provide. E.g. under Section 377 of Indian Penal Code, non-peno-vaginal penetrative sex between consensual adults is recriminalized. This Section is applicable to all, but MSM & TG may be singled out on account of their identity. □ Narcotic Drugs & Psychotropic Substance Act 1985 was amended (Feb. '14) to legalize certain provisions to secure PWID's health, but they can be arrested for consumption/or possession of drugs even in small quantities. □ Immoral Traffic (Prevention) Act 1956 does not directly penalise against FSW per se, but the Act bestows the police with special powers for arresting FSW & raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. □ Various Rights bodies need to be sensitized on the needs/issues of KP, PLHIV & children living with HIV & also on the existing punitive laws

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

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: Yes

Other specific vulnerable populations [write in]:

: No

Briefly describe the content of these laws, regulations or policies: •MSM & TG: Section 377 Indian Penal Code (IPC) considers unnatural/carnal intercourse against the order of nature. It includes non-penile vaginal sex between man & woman, man & man & man with animal & criminalizes the same (punishment upto 10 yrs.). Adult consensual same-sex contacts is decriminalized following Supreme Court verdict (Dec '13). •PWID: NDPS Act 1985 lays out a framework for drug control in India. It proscribes production/manufacture/sale/possession/& consumption of certain drugs & psychotropic substances as illegal; & made it illegal for any individual to engage in any type of transaction with regard to these substances. The Act was amended in 2014. The objective of the Act is broadened to include "promoting the medical & scientific use of narcotic drugs and psychotropic substances." However consumption/possession of "small" quantities of drugs continues to be punishable. •FSW: ITPA 1956 regulates sex work while penalizing trafficking or procurement & detention in organised sex work. The Act bestows the police with special powers for arresting FSW & raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. •TG: Andhra Pradesh (Telengana Area) Eunuchs Act 1329, Section 2 provides for maintenance of a register by the government that will contain the names & place of residence of all eunuchs residing in Hyderabad or at any other place...& 'who are reasonably suspected of kidnapping or emasculating boys' or other unnatural offences. • Section 320 IPC penalises emasculation as causing grievous personal harm. • Section 159, 160 IPC is intended to punish individuals disturbing public peace by fighting in a public space. •Some States have Policies preventing dissemination of IEC material on Life Skill Education since they are held to 'violate child pornography related laws'. •Prison manuals state that isolation rooms can be used for accommodating patients with Infectious/contagious diseases.

Briefly comment on how they pose barriers: Following laws creates obstacles for reaching out & providing KP & PLHIV with Health/HIV services. •Section 377 of the Indian Penal Code (IPC) criminalizes adult consensual same-sex contacts. It violates the fundamental rights of sexual minorities . •NDPS Act, 1985, amended in 2014, includes changes that are supportive to securing PWID's health by legitimizing OST & other harm reduction services. However, people who use drugs can be arrested for consumption/or possession of drugs even in small quantities (Section 27[a]), with punishment of up to 1 year. NDPS is strongly enforced. •Sections of ITPA empower police officers to arrest FSW, raid brothels for rescuing individuals forced into sex work or human trafficking. There is no differentiation between women forced into prostitution through trafficking & women who are voluntarily in sex work. Consent of women voluntarily in sex work is not sought & they are forced into rehabilitation homes. Clauses are used to harass FSW/arrest them under false pretexts. These raids drive FSW underground. •No recorded cases of the Andhra Pradesh (Telengana Area) Eunuchs Act, 1329 being applied exist; but the provisions violate TG's fundamental rights. •Provision under Section 320 of IPC criminalizes emasculation adversely. However the 2014 Supreme Court judgment, regarding recognition of TG as Third Sex, includes specific provisions for community members opting to undergo Sex Reassignment Surgery. There are instances of continuing malpractices in certain states. •IPC Sections 159, 160 are often used by law enforcement to detain & arrest FSW, MSM, TG in public spaces. These population tend to get driven underground, impacting outreach & prevention efforts. •Forcible segregation of prisoners on ground of their status violates their human rights & exposes them to S&D. In addition, entry for CSO has been restricted to provide HIV prevention & treatment services in line with the prison manual

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

Briefly describe the content of the policy, law or regulation and the populations included.: Laws or regulations to reduce violence against women are: •Domestic Violence Act 2005 provides for the protection of rights of women who are victims of violence occurring within the family and incidental matters. •Dowry Prohibition Act prohibits demand, giving & receiving of dowry in specific circumstances. •Sexual Harassment at workplace guidelines by the Supreme Court in 1997. Protection of Women against Sexual Harassment at Workplace Bill 2010 tabled in Parliament. •Various IPC sections aim to protect women against acts of violence e.g.cruelty by husband/relatives, etc. •Criminal Law (Amendment) Act 2013 provides

for amendment to sections of the IPC, Indian Evidence Act, and Code of Criminal Procedure, 1973 on laws related to sexual offences & adds new offenses to the IPC e.g. acid attack, voyeurism, etc. •Medical Termination of Pregnancy Act, 1971 legalizes termination of pregnancy on various socio-medical grounds & aimed at eliminating abortion by untrained persons in un-hygienic conditions. •Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 seeks to prohibit pre-natal diagnostic techniques for the determination of the sex of the fetus. Despite protection available to women under these Laws, timely grievances redressal continues to be a challenge, particularly for vulnerable women (including WLHIV, FSW). They get discouraged from accessing law courts because of insensitive procedures met out to them & delays in justice. Specific vulnerabilities of WLHIV, FSW are not effectively addressed in the existing laws or regulations. •Civil society CEDAW shadow report reflected challenges faced by WLHIV in India. Article 16, CEDAW is yet to be ratified. •Child marriage/early marriage is prevalent in parts of India. There have been instances of forced marriage. •Progressive legislations such as Domestic Violence Act are limited in their application for women experiencing violence in domestic setting.

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

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:: Human rights (HR) protection is mentioned in the following policies/strategies, but there are still cases of human rights violation: •Strategy & Implementation Plan for NACP IV. •GIPA policy. •Policy on gender mainstreaming. •Protection of Children in the Ministry of Women and Child Development scheme. • States e.g. Nagaland & Manipur have specific HIV policies. Civil society (CS) recommendations: •Existing policies need to be implemented in a sustained manner as there are cases of HR violation. •Certain practices carried out under the program e.g. classification of 'high volume / low volume sex workers' & the enumeration process are regarded by CS as violation of the privacy of FSW. •Current classification of PWID who inject drugs regularly & non-regularly limit the latter's access to essential harm reduction services. Also, provisions under the NDPS Act 1985 (amended in 2014) & NDPS Policy 2012 penalizes any person who consumes &/or possesses "small" quantities of drugs with upto 1 year imprisonment. • CS expressed their concern that information collected for line listing KP by DAC may result in discrimination in the absence of a strong mechanism to ensure consent and confidentiality. HIV Bill, once passed, will be a specific and key legislation for protecting rights of PLHIV and key population. Its passage in Parliament must be sustained.

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

IF YES, briefly describe this mechanism:: There are certain mechanisms in place for addressing S&D. •From the CS side it includes: o Crisis management systems exist under Targeted Interventions. o NGOs/ CBOs are engaging in crisis response at the field level across numerous states using specific strategies. o In certain states, cases recorded by NGOs/ CBOs are forwarded to SACS/DAC. • From the Government side it includes: o DAC & SACS are setting up desks for grievance reporting & crisis management. o HIV-positive people can report grievances at any police station. There is a designated police officer in each state. • Media has played a part in highlighting S&D cases against PLHIV. This though needs to be strengthened with focus on documentation of S&D against PLHIV. Comments & recommendation by CS: • While there is a process in place, implementation mechanisms need strengthening. There also remains a difference between existence of mechanisms & practical implementation. • There is S&D behavior met out to KP & PLHIV by various service providers &/or agencies. S&D acts as a deterrent for KP & PHIV from sustaining interaction with various service providers/agencies etc. •Recommendation is for the Woman's Commission & Woman's Mission to play an active role in also supporting aggrieved WLHIV & FSW. •Instituting specific centres that women can report to will be a positive step. • Support efforts to increase knowledge among the community (KP, PLHIV) on available mechanism to record, document and address cases of S&D experienced by them. •At the health service level: o There is need for a Health Ombudsman for lodging a complaint in case of denial of services. o It is recommended, that CS play a more active role in making use of instituted reporting services to report if there has been a denial of services.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: No

Provided free-of-charge to some people in the country: Yes

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: No

Provided free-of-charge to some people in the country: Yes

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: According to the Strategy and Implementation Plan for NACP IV: •Women living with HIV (WLHIV) and children identified with HIV are prioritized for ART treatment. •Key populations of FSW, MSM, Transgender, and PWID; followed by bridge population groups of migrants and truckers are prioritized for HIV prevention interventions. Civil society recommended that the package of services made available for HIV prevention include the following: •Free female condoms for FSW. •Greater focus on partners and spouses of KP. •Strengthen OST provision and scale up availability rapidly and its access. •Consider a more comprehensive package of services that include HIV related co-morbidities and co-infections (e.g. Hepatitis C, cervical cancer, etc.). • Needs based services for women who inject drugs. •Facilitate easier access to available services.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?: No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?: No

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

IF YES, Briefly describe the content of this policy/strategy and the populations included:: • National AIDS Control Prevention Policy 2002 refers to equal access for key and vulnerable populations to prevention, treatment, care and support services. • There are different prevention approaches for FSW, MSM, Transgender people and PWID, and prescribes a minimum package of services for each. • However the approaches and composition of services for key populations are not comprehensive. Also, it is essential to consider the needs of other vulnerable populations also such as women who inject drugs, vulnerable children (e.g. street-based children).

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?: No

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

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

IF YES, briefly describe the content of the policy or law:: YES, briefly describe the content of the policy or law: • HIV testing and counselling policy prohibits pre-employment HIV screening. The policy is articulated in the National Guidelines for ICTCT and in the National AIDS Policy of 2002. This was accepted by the Ministry of Labour in October 2009. According to Civil society, this policy is not being adopted / practiced by private sector. It is recommended that steps be taken to prevent pre-employment HIV screening. • HIV Bill includes detailed provision for prohibiting discrimination in the workplace. The Bill's ratification by Parliament is awaited.

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

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

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: No

IF YES on any of the above questions, describe some examples:: • India has several institutions for promoting and protecting human rights such as the National Human Rights Commission; State Human Rights commissions; Law Commission of India, etc. However: (1) On the whole, monitoring of human rights violations is in a nascent stage, by these Commissions and institutions. (2) Greater promptness in action is required for ensuring timely and effective protection of Human Rights. (3) As not all institutions in India are sensitized on HIV and punitive laws, it is recommended that steps be taken towards this. (4) The Press Council on India are watchful against sensational reporting.

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

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

b. Programmes for members of the judiciary and law enforcement⁴⁶ on HIV and human rights issues that may come up in the context of their work?: Yes

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

a. Legal aid systems for HIV casework: Yes

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

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

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]::

: No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 5

Since 2011, what have been key achievements in this area:: Key achievements since 2011 have been the following: • The recent 2014 Supreme Court judgment provided Transgender with the status of Third Gender. This verdict has already had an enabling effect with Transgender exercising many of their rights. • HIV Bill was introduced to Parliament in 2014 and its passage moving is in the Rajya Sabha (Upper House of Parliament). With the first reading over, reference has been made to Standing Committee. • Supreme Court judgment on the case Novartis VS India has been a landmark. It opened the way for

Indian companies to be allowed to continue producing cheaper generic versions lifesaving medicines (cancer). • Strong civil society led effort to seek judicial recourse on the matter of Supreme Court judgment on Section 377. Multiple Review Petitions filed by civil society and 1 by Government, in Supreme Court on January 2014, but dismissed. A curative petition is filed and scheduled for an open court hearing.

What challenges remain in this area: Challenges remaining in this area include: • Existence of punitive laws. They include the following: o Section 377 of the Indian Penal Code considers unnatural or carnal intercourse against the order of nature which includes non-penile vaginal sex between man and woman, man and man and man with animal and criminalizes the same with punishment of up to 10 years. o Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 amended in 2014. Continues to penalise the consumption/or possession of “small” quantities of drugs continues to be a punishable offence. o Immoral Traffic (Prevention) Act 1956 regulates sex work while penalizing trafficking or procurement and detention in organised sex work. The Act bestows the police with special powers for arresting sex workers and raiding brothels for rescuing individuals forced into sex work or cases of human trafficking. o Laws relating to prisoners and HIV need to be addressed. • A comprehensive Hepatitis C Policy for addressing vulnerabilities of injecting drug users to HIV- Hepatitis C infection—and access to appropriate treatment services—is required. • International trade policies and laws, specifically TRIPS and IPR related issues, could jeopardise the production and manufacturing of high-quality, low-cost medicines. Strong advocacy is needed to prevent this and facilitate essential treatment access for all.

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 4

Since 2011, what have been key achievements in this area: Key achievements since 2011 have been the following: • Following the Supreme Court judgement in April 2014 (Case name: National Legal Services Authority VS Union of India) Transgender people have now received the status of third gender. • In 2012, Ministry of Social Justice and Empowerment set up a high level committee to look into Transgender peoples’ issues. • In 2013, Ministry of Social Justice and Empowerment set up an experts committee to give key policy inputs to Government on Transgender peoples’ development issues. Recommendations of the group were tabled before the Supreme Court of India. • Governments of Chhattisgarh and Delhi State issued various Government Orders on Transgender peoples’ issues. Example: issuance of Labour cards for them in Chhattisgarh and inclusion of Transgender people in poverty census and Antyodaya Anna Yojana schemes in Delhi. • Maharashtra State’s women and child policy includes two chapters dedicated to issues of women in sex work and TG. It outlines key development measures, and enhancing livelihoods and social protection schemes for them. • Civil society CEDAW shadow report included issues faced by Women living with HIV in India.

What challenges remain in this area: The country needs to work more towards: •Effective implementation of existing supportive laws & policies. •Repeal or modify of punitive laws, policies & practices. •Facilitate civil society involvement in monitoring violation of rights with various institutions & existing bodies. •Enabling PLHIV & key populations’ easier access to legal systems with focus on delivering speedy justice. •Law enforcement agencies need to be sensitized on the requirements and concerns of PLHIV, & all key population groups and to use discretion to not harass based on interpretation of certain sections of specific Laws, e.g. ITPA. • Article 16, CEDAW to be ratified. •On account of the prevailing S&D experienced by PLHIV & key populations from service providers across various sectors (HIV, Health, Judicial, Law enforcement, etc.)—in public and private sectors—a suggestion is on the need for: (a) Further improvement in the quality of various sensitisation initiatives that are carried-out in the public Health sector. (b) Expand appropriate interventions across all key public sectors & also encourage the private sector for the same. (c) There is need for periodic refresher trainings, periodic re-sensitisation efforts to address issue of staff turn-over and maximise the coverage of these trainings/programs/interventions in public sector. (d)Consider steps to sensitise the general public, especially those in remote area with limited access to multi-media, where there is limited awareness.

B.IV Prevention

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

IF YES, how were these specific needs determined?: Specific needs are determined through: •Strategic information on KP generated via (i) program reporting on SIMS platform from site level upwards, (ii) population size estimates, (iii) mapping KPs, (iv) evidence generated through research studies, etc. •Inputs from Targeted Interventions implemented by NGOs/CBOs for HIV prevention among KP & and bridge populations (high-risk migrants & long distance truckers) through SACS. •Community inputs to planning certain interventions e.g. Harm reduction program. •Pilot projects, e.g. interventions focused on women who inject drugs in North East region, prison inmates etc. conducted to further recognise KP & vulnerable populations’ distinct needs & determine response mechanisms. Challenges include: (1) Design of Targeted Interventions & SOP are developed at center & enforced uniformly across India to support minimum operating standards. But increasing evidence/feedback from the field points to diverse needs among KP across states/regions which necessitates flexibility to make interventions more relevant.(2) Discussion on package of interventions included to Targeted Interventions needed. (3)

Need for easier access to HIV prevention interventions, especially remote areas. Strengthen linkages with other facilities for HIV treatment & care; OIs (e.g. TB), co-infections & co-morbidities (HCV). (4) KPs' & PLHIVs' access to the wider health services needs to be enabled. (5) Preventing stock-outs of commodities. Enable availability of condoms at treatment centres also. (5) Stronger HIV-Health linkages for KP needed & access to broader range of services. (6) Stronger focus to reach vulnerable populations also e.g. spouses/partners of KP, women who inject drugs. (7) Recommendation for private Health sector to adhere to treatment guidelines adopted by the Government. (8) Need to increase the evidence base & secondary analysis to guide interventions. (9) S&D is still existent and remains a barrier to service access.

IF YES, what are these specific needs? : Post 2012 specific needs related to ensuring:

- Strategies adapted to both men having sex with men and Transgender people needs as separate population groups.
- Rolling-out certain separate interventions for Transgender at the implementation level.
- Expansion of OST for people who inject drugs. There is further recommendation for:
- Making interventions more relevant and responsive to the local needs of the people—considering the diverse state and regional-level requirements and epidemic trends—and awarding a level of flexibility by having state or regional-level Operating Procedures. Community representatives' engagement could be further strengthened and their knowledge base capitalised on.
- Conduct discussion on the composition of the package of HIV prevention interventions for all key populations.
- Particular reference made to:
 - o The need for scaling-up quality OST and harm reduction services for people who inject drugs.
 - o Including appropriate types of condoms with lubes for men having sex with men and Transgender.
 - o Including female condoms for female sex workers.
- Increasing prevention focus to address vulnerabilities of partners and spouses of key populations, women who inject drugs.
- Strengthen HIV-Health linkages and linkages between prevention and treatment, care and support centres for key populations.
- o There is need to detect and treat Hepatitis C among people who inject drugs and other affected.
- Taking further steps to measure and address stigma and discriminatory behaviour experienced by PLHIV and key population.

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Agree

Condom promotion: Disagree

Harm reduction for people who inject drugs: Disagree

HIV prevention for out-of-school young people: Strongly disagree

HIV prevention in the workplace: Disagree

HIV testing and counseling: Disagree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

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

Prevention for people living with HIV: Agree

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

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Agree

School-based HIV education for young people: Disagree

Universal precautions in health care settings: Disagree

Other [write in]:

:

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 5

Since 2011, what have been key achievements in this area:: Under the national strategy to intensify and consolidate prevention services, and increase access; following were some of the key achievements. • Increased coverage of the HIV prevention programme among key populations. • An expressed aim to expand prevention interventions among Transgender now that the mapping and size estimations exercise is completed. • Revision of the migrant strategy and roll-out. • Increase in the number of service centres, particularly integrated counselling and tested centres. • Increasing coverage of women receiving multi-drug regimens in select pilot states for preventing vertical HIV transmission under the PPTCT programme. National policy decision made in 2014 to expand roll-out multi-drug regimens across India. • Civil society was involvement in program planning / designing including towards interventions targeted at Transgender population and people who inject drugs. While noting the achievements, there are some challenges or gap areas that will need to be addressed in order to make HIV prevention efforts more comprehensive and more pertinent. These are listed in response to the next question.

What challenges remain in this area:: Previous years' focus was centred on expanding service provision & not much on quality. Recommendation is that focus now shift to improving quality, re-look at the package of interventions for KP & PLHIV & make it comprehensive. Scale-up interventions focusing first on areas where indication is of rising epidemics. Details below. HIV prevention services package for KP & sub-groups needs to be more innovative, comprehensive & responsive to meet current & local needs. Interventions needed to reach KPs' partners & other vulnerable populations e.g. women who inject drugs, street-based children etc. Some recommendations on the package are: (a) Inclusion of 'treatment as prevention' strategy, condoms & lubes for MSM & TG, female condoms. (b) Facilitate & ensure KP & PLHIV access to Health service to address OIs, co-infections & co-morbidities. Develop & implement a comprehensive operational plan for strengthening HIV-Health service linkages. E.g. FSW access to reproductive health services, PWID access to Hepatitis treatment, care. (c) Measures needed to address S&D, & other service access barriers. (d) Provision of psychosocial support to KP, PLHIV, their partners etc. Measures to prevent stock-outs of essential commodities needed. Need to bring more people under the gambit of services. Widen definition of KP & also of vulnerable population to include women who inject drugs, street-children etc. Effective mechanisms needed to prevent LFUs. Recommendation is supporting an increased role for CBO/NGOs in this endeavour. Coordination of TG interventions between the different implementers is required. Workplace HIV/AIDS policy & programmes exists, but implementation is limited to certain geographical areas. Need is to have all areas covered. Recommendation for private sector to include it. 2013 WHO Treatment Guidelines needs to be practised holistically at all service-points. Much scope to improve quality of pre-HIV test & post-test counseling.

B.V Treatment, care and support

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

IF YES, Briefly identify the elements and what has been prioritized:: The package of treatment, care and support services include the following priority elements: • Treatment scale-up o Adoption of 2013 WHO Treatment Guidelines on HIV. Threshold for treatment initiation set at CD4 500. o Provision of free treatment for first line ART, second line ART. A recent decision is to provide third line ART through Government soon. o Scale-up of treatment centres at the sub-national level as a means to facilitate peoples' easier access to services. There is an extensive network of ART centres, ART plus Centres, Link ART Centres, Link Art plus Centres, etc. o However, despite the efforts, treatment access is a challenge especially for PLHIV in geographically remote areas such as in the North East. It is particularly so for second line ART. Innovative methods to address this are essential. • Greater focus is awarded to CD4 testing and monitoring for first line ART and viral load to support second line ART. • Regarding Prevention of Parent to Child Transmission of HIV, India announced its policy decision to adopt multi-drug regimen for preventing vertical transmission, in beginning 2014. Aim is to ensure coverage of all states under this new regimen. In 2013, this new regimen was being provided only in few states on pilot basis. • Management of opportunistic infections, including Tuberculosis and STI/Reproductive Tract Infections. • Community Support Centres have been instituted under NACP IV. • Greater emphasis is on providing social protection through various State level measures introduced for travel, nutritional support, children's education, etc. across certain states

Briefly identify how HIV treatment, care and support services are being scaled-up?: Following are some the key efforts to scale-up HIV treatment, care & support services: • Key policy decisions were taken by Government. E.g.: o Adoption of the 2013 WHO Treatment Guidelines for HIV. o Policy decision to adopt & roll-out multi-drug regimen for PPTCT across country in phased manner. o Steps are being taken to encourage convergence of NACP-NRHM at service-delivery level. • Focus on infrastructure expansion. E.g.: Continued expansion ART center network, etc. o With greater focus to increase HIV testing, number of ICTC centers also scaled-up. While recognising the positive steps taken, there were certain challenges which can & need to be addressed for increasing the efficiency and effectiveness of the Treatment, Care & Support Program: • Instances of stock-outs of essential commodities, specifically including medicines, had a significant effect on treatment continuity, adherence. • Steps to effectively manage ART adherence needs also to be considered. Viral load monitoring has been a challenge for many PLHIV. Although no. of viral load centres increased, however, given the geographic expanse & dispersion of PLHIV; there is need to ease viral load monitoring access, especially for those living in remote areas. • There remains a level of stigma and discrimination at the health care settings which becomes either a deterrent to accessing services regularly. • Comprehensive strategy & steps for provision of Hepatitis treatment & care needed. Key recommendation is that this be included as part of the comprehensive package of services. • More effective OI management required. • Strategy of 'treatment as prevention' to be considered. • Facilitate KP & PLHIVs' access to critical Health services • Steps to address treatment illiteracy and / or sensitisation among the service providers working within the larger Health sector recommended. • Increased treatment awareness among consumers.

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

The majority of people in need have access to...:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Disagree

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

HIV testing and counselling for people with TB: Agree

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

Nutritional care: Strongly disagree

Paediatric AIDS treatment: Disagree

Post-delivery ART provision to women: Agree

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

Post-exposure prophylaxis for occupational exposures to HIV: Agree

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

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Disagree

TB preventive therapy for people living with HIV: Strongly disagree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Disagree

Other [write in]: Second line ART, Viral load testing, HCV testing, drug resistance testing (Disagree)

: Disagree

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 5

Since 2011, what have been key achievements in this area: The key achievements since 2011 include the following: • Steps for provision of (1) more effective regimens for treatment and (2) enabling its early initiation. India formally adopted the 2013 WHO treatment guidelines for HIV and multi-drug regimen for PPTCT in 2014 and this is planned for rolled-out across country in 2014-15. • A decision is also made on third line treatment and it will be provided by Government soon. • Rapid scale-up of people receiving first line ART. Scale-up up for treatment centres, particularly for first line. • Measures by State Governments to provide social protection to PLHIV through various state-specific schemes such as for travel to ART centres, nutritional support, etc.

What challenges remain in this area: In recognition of the challenges (mentioned above), the corresponding recommendations are as follows: • Identify innovative mechanisms & processes to enhanced HIV-Health service integration via greater inter-Ministerial collaboration, & meeting the overall Health & care needs of KP & PLHIV. • Focus on quality & comprehensiveness of counselling & psycho-social support. • Need for quality & comprehensive treatment of HIV, co-infections & co-morbidities. o PWID recommend Hepatitis testing/ diagnosis & treatment included to the overall interventions package. o Cases of PWID dying from high levels of overdose iterated by CS representatives, & all made for necessary provision to prevent this. o Overcome operational-level challenges of HIV testing, counselling, & ART for people with TB. Recommendation for regular TB screening. • Centres providing treatment for Opportunistic Infections need to be scaled-up. • Further steps needed to minimize no. of LFUs. • Strengthen infrastructural facilities, particularly for viral load. Consider ways to facilitate people’s access to these services in remote areas. • CS encourages an increased opportunity for them to (1) collaborate with partners, Government, & (2) engage in the planning, programming & implementation processes at the national, state & district levels.

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 5

Since 2011, what have been key achievements in this area: • There are 7 Regional Paediatric Centres and which are upgraded to Centres of Excellence for care and support to infected children. • A draft policy framework for Orphaned and Vulnerable children has been developed but is yet to be endorsed. • A few pilot projects focused on meeting the HIV related needs of orphans and vulnerable children are ongoing. These are mostly initiatives at state level implemented by civil society organizations with some level of support from state governments. For example, housing / hostel with care facilities for HIV positive children.

What challenges remain in this area: • A recommendation is to formulate a comprehensive policy or strategy to address the needs of orphans and other vulnerable children, such as school drop-outs, street-based children, etc. • Strengthening mainstreaming of HIV services for children living with HIV within the existing health care system. • Ensuring provision of care and support for children living with HIV or affected with HIV; particularly orphans, street-based children, and marginalized children across States. This should include educational and nutritional support for children living with HIV. • Increase awareness and knowledge not only on HIV prevention, but also on treatment, care and other support services provided by Government for the people through various means. To target school going youth, adolescent educations need to be resumed in all states where they were suspended; and ensure that the curriculum includes comprehensive knowledge. Inventive methods to reach street-based and other marginalised children need to be considered.