Social Assessment of HIV/AIDS Among Tribal People in India

A Report

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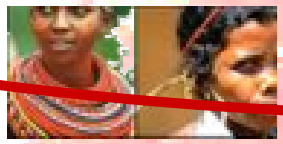
Submitted to
NACP-III Planning Team, New Delhi



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Social Assessment Team
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
AP	Andhra Pradesh
ARV	Anti Retroviral
ART	Anti Retroviral Therapy
BSS	Behavioural Surveillance Survey
CHC	Community Health Centre
CMIS	Computerized Management and Information System
CMO	Chief Medical Officer
CSW	Commercial Sex Worker
DACS	District AIDS Control Society
FGD	Focus Group Discussion
FHAC	Family Health Awareness Campaign
FSW	Female sex Worker
GIPA	Greater Involvement of People Living with and directly affected by HIV/AIDS
GOI	Government of India
HIV	Human Immune Deficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
MO	Medical Officer
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NACP I	National AIDS Control Programme, Phase 1
NACP II	National AIDS Control Programme, Phase 2
NACP III	National AIDS Control Programme, Phase 3
NGO	Non Government Organization
PLWA	People Living With AIDS
PLHA	People Living with HIV/AIDS
PLWHA	People Living with HIV/AIDS
PMO	Principal Medical Officer
PPTCT	Prevention of Parent to Child Transmission of HIV
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Programme
SA	Social Assessment
SACS	State AIDS Control Society
SAEP	School AIDS Education Programme
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TI	Targeted Intervention
TOR	Terms of Reference
VCT	Voluntary Counseling and Testing
VCTC	Voluntary Counseling and Testing Centre

SOME KEY TERMS

Risk: A variety of demographic, behavioural and social factors place people at risk for becoming infected with HIV and other STIs. Traditionally cited risk factors include, e. g., age, multiple sexual partners, partners with multiple sexual partners, history of STIs, and drug and alcohol use. Anyone who engages in behaviour that exposes him or her to HIV is at risk for infection.

Vulnerability: More recently, there has been a growing recognition that in addition to an individual behaviour, certain social, economic, and political forces makes people or groups of people vulnerable to infection. Some factors that affect social vulnerability include gender inequalities, economic power, youth, cultural constructs, and government policies[1].

High risk states or high prevalence states are the states having infection of over 1 percent of antenatal care (ANC) recipients and over 5 percent among high risk groups

Low Prevalence States are the states having HIV prevalence less than 5 percent in high risk groups, and less than 1 percent among antenatal women[2].

[1] Engender Health : HIV and AIDS – online minicourse (2003), module *3,* 1
http://www.engenderhealth.org/res/onc/hiv/transmission/hiv3p5.html
[2] NACO Annual Report 2002-03; 2003-04 : 19

EXECUTIVE SUMMARY

1. Background

The National AIDS Control Programme (NACP) Phase III aims to go beyond the high risk behavior groups covered by Targeted Interventions. This would entail extension of interventions to populations that are vulnerable to HIV such as the tribal people and socially disadvantaged sections of the population in both rural and urban areas. A rural risk/vulnerability assessment has already been carried out, and the present assessment has focused and limited itself to the study of tribal people only.

2. Objectives of the Social Assessment

The SA among tribal people has the following objectives:

- To undertake a comprehensive SA that documents the prevalence and risk of HIV/AIDS among tribal people,
- To understand their levels of knowledge, social and behavioural causes and consequences of HIV/AIDS (including stigma),
- To assess current strategies used for PDTC of HIV/AIDS in order to ensure appropriate programme design and implementation to reduce the spread of HIV/AIDS and improve its management.
- To provide information for pre-project stakeholder consultations and to design continuous stakeholder consultations in the programme.

3. Assessment Methodology

SA was a qualitative research and the information was collected through;

- Review of literature
- Primary assessment among tribal people; and programme implementers and service providers
- Relevant literature survey
- Analysis of the various policy documents
- Analysis of NACO Project documents and assessment reports available

4. Basic Information about Tribal people

The following are the salient findings regarding behavioral and other practices that are relevant to the programme planners:

- Low awareness and knowledge regarding STI/HIV/AIDS except in Manipur
- Widely varying sexual practices (high level of pre-marital and extra marital sexual practices) and contact with external high risk population make them vulnerable
- Specific communication strategy designed to suit the needs and culture of the target group in local dialects would be necessary. The choice of medium for communication would also be critical. Folk media, Inter Personal

Communication and messages through influencer groups could be main choices

- Non-availability and/or lack of access to health care facilities were one of the main factors discouraging health seeking. Trust in faith healers and non qualified private practitioners and easy accessibility made them rely on these sources for seeking treatments for illnesses. Role of such providers in referral needs to be reckoned in programme design
- Gender bias towards males for health care seeking needs to be addressed
- Knowledge regarding STI and symptoms are low and misconceptions that exist exasperates this situation
- High level of stigma associated with STI and HIV/AIDS is a challenge that needs to be addressed
- Youth are emerging as a highly vulnerable group in these areas

Implications of Basic Information Findings

- The tribal people are at risk in terms of HIV and hence it is essential that interventions designed specifically to meet the requirements of the tribal people
- Communication strategies and media selection needs to be done in accordance with the findings of the media habits as outlined in the study
- The instance of high level of pre-marital and extra-marital sexual practices and sexual exploitation also makes them vulnerable and this aspect needs to be reckoned while designing interventions.
- The communication needs to address in the first stage increasing knowledge and awareness among the tribal people regarding the STI/HIV/AIDS as well as remove the myths and misconceptions existing in order to reduce stigma
- The strategy of training and using faith healers and other private practitioners in whom the tribal have faith in to motivate the population for bringing about a better health seeking behavior
- The infrastructure of health facilities need to be improved and human resources trained and posted in this geographic area to increase access and use of these facilities
- The capacity of the NGOs also needs to be built in this region to effectively implement interventions

5. Policy Environment

The following policies have been examined and analyzed for their implications on the Prevention-Diagnosis-Treatment and Care (PDTC) for the tribal people:

- National HIV/AIDS Prevention and Control Policy
- National Health Policy 2002
- National Population Policy 2002
- National Rural Health Mission-Vision Document
- National HIV/AIDS Bill
- Manipur State Level Policy on HIV/AIDS
- The National RCH and RNTCP Program Documents

Overall findings from the review

There are no specific policies that directly impinge or address the tribal issues but there is enough scope to derive from the various policies that there are areas that can be interpreted to be applicable to the Tribal people. This has been discussed in the interpretation section of each policy. However, it is concluded that specific issues addressing the requirements of tribal people needs to be developed separately drawing from the different policies that are already in place. This exercise needs to be carried out on a priority basis.

6. Institutional Issues

- A special function at the National and State level needs to be created and positioned to deal with issues relating to policies, coverage and implementation of interventions among the tribal people and other socially disadvantaged sections of the population who are vulnerable to HIV
- The district level planning envisaged during NACP III needs to identify the vulnerable and socially disadvantaged people as well as the tribal people that need to be covered in the different districts of each state
- The Governing Board and Executive Committee of each SACS can be expanded to include members from the Social Welfare Board and Tribal Development departments for better understanding of the requirements of the populations and appropriately plan for intervention and services in those areas
- The convergence with RCH II especially in the areas of Tribal Plan, Urban Poor and the approaches to mainstreaming gender and equity can be attempted in order that the service availability and service provision can be linked. The policy and goals can be studied and the same be tied up with in the state PIP for serving the tribal people and other marginalized and socially excluded population
- Behavioral studies using a ethnographic approach need to be carried out in different tribal and rural belts to better understand the risk and vulnerability factors of the specific population in order to design programme and interventions for these populations
- Capacity building of the NACO and SACS staff on the Social Development issues, gender, equity and Social Exclusion needs to be provided in order that the staff are sensitized and appreciate the necessity to include and mainstream such aspects into the programme
- District level structures need to be created for planning the district level HIV/AIDS intervention with evidence for planning and capacity needs to be built on different aspects of programme planning and management

7. Recommendations

National level - Policy Related

1. Multi-pronged approach may be adopted to reach out tribal people.

2. A policy decision regarding the necessity to intervene with this group needs to be taken.

3. Convergence needed to bring about and derive advantages of the synergy between NRHM and the HIV/AIDS programme.

4. Create a function of Social development, within NACO and SACS to address social development activities and to identify, assess and design interdisciplinary research priorities and actionable knowledge strategies within SACS and NACO.

National Level – Programme Related

5. Request the states to carry out a mapping exercise in order to identify tribal belts and to gather information on HIV/STI prevalence among tribal through the sentinel surveys.

State level

6. Convergence between NRHM and HIV/AIDS control programme should be brought about.

7. There is a need to have a communication strategy on stigma, discrimination, care and support more clearly.

8. There is a need to collaborate or co-ordinate with Department of Tourism as the tourists are involved in sexual activities with tribal women.

District Level

9. The programme should address the gap of non availability of disaggregated data on prevalence rates for different social groups.

10. There is need to initiate focused intervention for tribal group.

Public-Private Partnership

11. Collaboration sought with corporate sector for their involvement in the prevention and education programme as well as in provision of services such as STI.

12. Advocacy for participation of development and private sector agencies and liaison with international and national agencies engaged in developing sustainable livelihoods and reducing vulnerability also need to be thought about.

Tribal Action Plan

India has the second largest concentration of tribal population in the World. Indian tribes constitute around 8.2 percent of nation's total population (Census 2001)[3] and north eastern states are predominantly tribal-populated States (IDSP 2003)[4]. Poverty and poor infrastructural development in tribal dominant areas have been the main reasons contributing to the inability of health programmes in reaching out to tribal populations, which includes the National AIDS Control Programme.. The available literature along with findings from the tribal assessment undertaken by ORG Centre for Social Research in 2006, provide specific evidence to establish the tribal population in India as being particularly vulnerable to HIV/AIDS and help in identifying specific needs of the tribal groups with regard to HIV/AIDS.

The assessment reaffirmed that illiteracy, migration and poor access to media makes the tribal population socially vulnerable. With regard to HIV vulnerability, studies have reported that tribal women are particularly vulnerable to HIV/AIDS since they commence sexual activity at an early age. Sexual practices varied widely, sexual relationships out of wedlock were reported to be a very common phenomenon. Girls and boys staying together before marriage was a socially acceptable norm. Couples were also at liberty to divorce and remarry. Males were involved in premarital or extra marital sex. Condoms were generally not used, as these were disliked. Except in Manipur, by and large, the tribal communities were unaware of STIs and HIV/AIDS. Awareness was lower among women. In all (except Manipur) states the awareness regarding services for prevention, diagnosis, treatment and care for STIs and HIV/AIDS were low amongst tribal people. Treatment seeking behavior for most health problems including STIs, revealed initial resort to home remedies or self medication by buying medicines over the counter from grocery or petty shops (in Manipur), followed by visits to the traditional healers. Other studies have also reported that due to stigma and shame associated with RTIs/STDs women suffering from RTI / STIs did not consult any physician unless the problem became very acute. Health facilities like the CHC/PHC were reported to be visited only when the problem became unbearable. Private health facilities were used, particularly when the location of public sector facilities was not convenient. Access to health care is yet a problem for tribal people (IDSP 2003) because of scattered settlements and difficult terrain, inadequate accountability and monitoring of health service delivery to tribal people, unhelpful attitudes of health service personnel, non availability of manpower at health facilities etc. (THDP 2003)[5].

No specific interventions had been started among tribals in the study areas by the government, private or public sector collaborators. In Andhra Pradesh, Rajasthan and Manipur, these populations were covered under the interventions designed for the high-risk (CSW and migrants) and other groups. Very few NGOs, were reported to be working specifically with tribal people on HIV/AIDS. NGOs in some tribal areas of Manipur, Rajasthan and Andhra Pradesh were seen to cover tribal communities under their TI programme. There was a dearth of IEC material communicating in local dialect of tribal people.

Issues covered under proposed Tribal Action Plan

1. Integrate tribal and social development issues in the HIV/AIDS programme at every level

[3] Census of India. 1991 Part II B (i) PCA- General Population (Vol. I & II). Downloaded from http://www.education.nic.in/htmalweb/stat1.html.

[4] Integrated Disease Surveillance Project 2003: Tribal Development Plan. Downloaded from http://www.mohfw.nic.in/TDP.pdf.

[5] Tribal Health Development Plan. Tamil Nadu 2003. Downloaded from http://www.tnhealth.org/notification/tdp.pdf

2. Systematize knowledge management on HIV/AIDS among Tribal people for developing interventions among them
3. Increase accessibility of the range of services under the NACP to tribal people
4. Work with development partners and public and private sector enterprises to improve HIV/AIDS prevention and control among vulnerable and tribal people

Framework considered for the plan

In Tribal Action Plan, against each of the above issues, a set of actions have been suggested under the column of "Actions to be undertaken"; the organizations who are expected to be overall responsible for undertakeing the suggested actions under the column of "agencies that can effectively undertake activities"; the steps involved in implementation of these activities under the column of "Implementation Process"; the suggested time of iinitiation of these activities under column " Time duration and the frequency of the activities to be undertaken"; the process and output indicators to assesss the extent of successful implementation of suggested actions under the column of "Possible monitoring mechanisms/indicators" has been mentioned. In the following paras, an attempt has been made to summarize the suggestions made in the action plan.

1. Integrate tribal and social development issues in the HIV/AIDS programme at every level

Integration of tribal and social development in HIV/AIDS programme at every level would call for some actions to be taken in the intial period of NACP-III. The actions include (i) ensuring inclusion of socio-economic and cultural dimensions of tribal people in the existing NACO policies and programmes. (ii) integrating HIV/AIDS programmes with NRHM and Tribal Development Programmes at all the three levels. (iii) advocacy for sensitizing officials and functionaries of Health and Tribal departments on issues of HIV, social development with a special reference to vulnerable and tribal groups. These actions may be taken in the intial period of NACP-III (iv) training 'action-agents' at every level for effective communication and implementation of the Tribal Action Plan.

2. Systematize knowledge management on HIV/AIDS for developing strategic interventions among tribal people

During NACP I and NACP II efforts have been made in HIV high prevalence states and some of the High-risk states including Gujarat and Delhi wherein communication strategies were formulated and disseminated with the help of IEC collaborative media products (TV, radio and print) in collaboration with various government and non-government agencies at national and international level. This needs to be extended to the tribal communities in particular to get a multi-pronged and multi-faceted effect of the communication interventions on HIV/AIDS prevention and control as also to generate and disseminate evidence base on vulnerability of tribals to STIs and HIV/AIDS in order to develop strategic interventions among them. In this regard, in the initial period of NACPIII, formative research for developing interventions among tribal groups may be formulated which would further consolidate the efforts on dissemination of evidence based information. Mass media centric programmes have proved to have limited acceptability in the past, while the quality of IPC efforts suffered to a large extent. Tribal populations are quite close knit and at the same time very distant from the new, globalised India. Hence, Inter-personal communication (IPC) has a major role to play in dissemination of information among this population, which has had limited exposure so far.

In year 2, a "KNOWLEDGE CENTRE" at NACO for consolidating and disseminating knowledge on sexual health and HIV/AIDS issues pertaining to tribal groups may be formulated. Subsequently, to identify factors that increase "HIV/AIDS vulnerability" amongst vulnerable and tribal populations, it is imperative to support more research studies. There is also a need to review and document ongoing interventions and related research among vulnerable and tribal groups from time to time as an ongoing activity under NACP-III. Lack of focus and prioritization of messages has lead to a very close-ended behaviour change. It is important to avoid dissemination of fragmented information, which most often leads to spread of 'mis-information' rather than 'information'. Information disseminated through the Knowledge Centre should also focus on other areas of behaviour change to lead to a significant change in the society. Tribal populations are geographically as well as culturally 'difficult-to-reach' as compared to communities in the non-tribal areas. Hence, a comprehensive package of mass communication and IPC is imperative to target behaviour change among this population. Also, monitoring and follow-up of these efforts forms an important part of this package, as also, the efforts should be more synergised and continous rather than event based. Establishment of an entity like the Knowledge Centre can ensure this happens.

3. Increase access to the range of services under the NACP for tribal area
Awareness plays a critical role in access of services by the target groups.

Poor physical access of tribal population to diagnosis and treatment under the NACP has been reported due to factors like difficult terrain and sparsely distributed tribal population in forest and hilly regions, locational disadvantage of primary health institutions (PHIs); longer distances to travel to reach to VCTCs and PHIs and weak primary health care infrastructure including VCTCs. Considering the fact that awareness is a major limitation for access of services wherever these are available, advocacy efforts in the tribal areas should focus on creating awareness of mere presence of diagnostic and treatment facilities in the vicinity. This could be done by involving the local leaders, anganwadi centres and schools and by strengthening the capabilities of 'change-agents' at grass root levels. Some actions to increase acess to the range of services may be taken in the year 2 and 3 of programme, for example, Targeted Interventions (TIs) among most vulnerable tribal groups may be extended, ICTCs (stationary/ mobile) catering tribal areas may be established and their effective functioning would also need to be ensured. Services like condom promotion, nutrition awareness and hygiene and health education should be extended among tribals. Access to effective IEC/BCC for HIV prevention and referral systems to increase the utilization of HIV/STI/RTI services may be improved and it would be an ongoing process.

4. Work with development partners and public and private sector enterprises to improve HIV/AIDS prevention and control in tribal people
Operationalising capacity of communication programmes varies considerably with states and hence, the need for IPC to strengthen efforts through IEC and BCC, could be made possible through hand holding with development partners who have strong hold at grassroot level as well as segment specific targeted communication. Public private partnerships could be a link to strengthen operationalising capacity within tribal communities, involving positive people's networks. A vital step would be develop synergies between NACO and SACS, between partner ministries and departments and between different media channels like mass media, mid media to strengthen advocacy activities and ensure effective dissemination of IEC material. The in-flow of funds needs to be monitored and outflow channelised so as to make significant, effective and complete utilization of available resources.

With regard to this, public private partnership for IEC, BCC and prevention strategies that includes promotion of condoms, mobile vans, referral services, adoption of ICTCs and training of medical staff and use of electronic media in media dark areas, may be ensured on continuous basis during the entire span of the programme.

The implementation process for each of the suggested actions and their possible monitoring indicators under above mention four areas has been illustrated in the detailed action plan given below.

Tribal Action Plan

Goal: Reduce vulnerability of tribal people to HIV/AIDS through ensuring equitable access to comprehensive care and support under the NACP III

POLICY

Objectives	Actions to be undertaken	Agencies that can effectively undertake activities	Implementation Process	Time duration and the frequency of the activities to be undertaken	Possible monitoring mechanisms
Integrate tribal and social development issues in the HIV/AIDS programme at every level	Ensure inclusion of socio-economic and cultural dimensions of tribal people in the existing NACO policies and programmes	NACO & SACS	• Formation of TCSG* at NACO for the entire duration of NACP III • Associate an official preferably Jt Dir (IEC) at NACO and his counterpart at SACS to address issues of tribal and social development • Ensure identification of vulnerable tribal people by states and prioritize coverage in phased manner • Plan stakeholder consultations at regional level involving SACS for preparing state/district specific strategies	• In the initial period of NACP-III	NACO policies and programmes make adequate mentioning of specific vulnerable groups including tribals
	Integration of HIV/AIDS programmes with NRHM and Tribal Development Programmes (National, State and District Level)	• NACO & MoHFW • SACS & Dept of Health • DAPCU & District Health Society	• DG (NACO) to be a special invitee in the steering committee meetings of NRHM to discuss the ways and means of integration • PD SACS to be a special invitee in the meetings of State Rural Health Mission • The Point person at the state level to liaise with health department, tribal welfare and social welfare Deptt., civil society organizations at state and district level • Consider existing socio-cultural dimensions among tribal people across the regions while planning interventions • Point person in consultation with National and State NGO Advisor to identify and engage mother NGOs working in HIV/AIDS • Capacity Building of NGO/CBOs (working on HIV and non-HIV issues) in tribal areas by mother NGOs.	In the initial period of NACP-III	• Guidelines available to integrate HIV/AIDS services with NRHM for the tribal areas

Objectives	Actions to be undertaken	Agencies that can effectively undertake activities	Implementation Process	Time duration and the frequency of the activities to be undertaken	Possible monitoring mechanisms
			• Point person to develop budget line items / have a provision of pooling funds from concerned deptt. in light of coverage of tribal people		
	Advocacy for sensitizing officials and functionaries of Health and Tribal departments on issues of HIV, social development with a special reference to vulnerable and tribal groups.	• NACO & SACS	• Point person in consultation with TCSG to formulate strategies for advocacy among officials and functionaries of concerned departments on issues of HIV, social development,	• In the initial period of NACP-III	• Advocacy and intervention strategies for vulnerable tribal groups developed

* TCSG (Tribal Consultative and Support Group): Represented by NACO, Funding Agencies, Ministry of Tribal Affairs, Ministry of Social Justice and Empowerment, Civil Society organizations, PLHA Networks

KNOWLEDGE

Objectives	Actions to be undertaken	Agencies that can effectively undertake activities	Implementation Process	Time duration and the frequency of the activities to be undertaken	Possible monitoring mechanisms
Systematize knowledge management on HIV/AIDS for developing strategic interventions among tribal people	Formation of a "KNOWLEDGE CENTRE" at NACO for consolidating and disseminating knowledge on sexual health and HIV/AIDS issues pertaining to tribal groups	• NACO/SACS • Development Partners	• Creating a platform for CBOs/NGOs/CSOs working amongst tribal groups on HIV/AIDS issues to share their experiences through thematic workshops • Strengthen government and NGO partnership	• Year 2 activity	Number of workshops conducted at national and state level on relevant themes
	Formative research for developing interventions among tribal groups	• NACO/SACS • Development Partners • Research institutions, Academic institutions, Tribal Research Institutes	• Ensure formative research conducted among tribal people at state level	• Initial period activity	• Number of research studies completed • To review the progress of the study conducted
	Review and documentation of interventions and related research among vulnerable and tribal groups	• NACO/SACS • Development partners	• Identification of interventions among tribal populations • Developing TORs keeping in mind the primary and secondary stakeholders of the interventions • Engaging consultants (for review) • Ensure mechanism for process documentations of the interventions involving NGOs/CBOs	• Ongoing process	• Number of reviews conducted • Number of process documentations • Number of consultants engaged
	Support research studies to identify factors that increase "HIV/AIDS vulnerability" amongst vulnerable and tribal populations (migration, sexual lifestyles, solicitation, exploitation, interaction with	• NACO/SACS • Development partners	• Identification and determination of the vulnerability of tribal groups and	• Year 2 and 3 activity	Number of vulnerable tribal groups identified and determinants of vulnerability identified

** A continuous stakeholder consultation is planned

SERVICE AND CARE

Objectives	Actions to be undertaken	Agencies that can effectively undertake activities	Implementation Process	Time duration and the frequency of the activities to be undertaken	Possible monitoring mechanisms
Increase access to the range of services under the NACP for tribal area	Extend Targeted Interventions among most vulnerable tribal groups	NACO/SACS/DAPCU	• Identification and capacity building of NGOs/CBOs to implement TIs among most vulnerable tribal groups	• Year 2	• Number of TIs introduced in tribals areas • Number of NGOs/CBOs trained
	Establish ICTCs (stationary/ mobile) catering tribal areas and ensure effective functioning	SACS & Deptt of Health DAPCU	• Establish ICTCs in the tribal areas nearer/within high risk districts (targeted areas) • Equip ICTCs with staff and facilities • Sensitize and train PHC workers, traditional birth attendants (dais), ASHA, Anganwadi workers, mahila mandals and encourage referrals • Operationaize ICTCs in tribal areas and ensure referral links to RNTCP microscopy centre and Community Care Centre • Engage and train local tribal youth as counselors	• Year 2 and 3 Activity	• Number of ICTCs operational (mobile/stationary) in the targeted areas • No. of training workshops held to sensitize staff/functionaries at different levels every quarter • No. of cases referred every quarter • Monthly submission of MIS reports to SACS/NACO

	Improve access to effective IEC/BCC for HIV prevention and referral systems to increase the utilization of HIV/STI/RTI services	• SACS & Dept. of Health • DAPCU • NGOs/CBOs	• Implement Family Health Awareness Campaign in areas of concentration of vulnerable tribal groups • Train community health volunteers and local youth to recognize symptoms of HIV/STIs/RTIs and seek/refer to appropriate facilities ▪ Sensitize, train and involve rural Private Practitioners and traditional healers in syndromic management of HIV/STIs/RTIs and also encourage referrals • Develop culture-specific/appropriate IEC messages using local dialects and appealing themes • Engage with local tribal youth, Ashram Schools Students from Tribal areas, mahila mandals, SHGs, PRI members to develop appropriate materials and themes ▪ Use appropriate media – TV, VCD parlours, community radio network, folk media and folk art ▪ Sites: Fairs, markets, tourists spots	Ongoing since inception	IEC strategies developed for each state No. of FHACs organized quarterly No. of training sessions organized for CHVs No. of rural PPs and traditional healers sensitized Monthly submission of MIS reports to SACS/NACO
	Extend Services for • Condom promotion • Nutrition awareness • Hygiene and health education	• SACS • DAPCU	• Undertake free distribution and social marketing of condoms at fairs, festivals and markets • Identify appropriate local places to stock and distribute condoms • Sensitize depot holders including PRI members/village head, school teachers, Anganwadi workers, ASHA, mahila mandals, SHGs, youth clubs and village priests	From later half of second year of NACP III	Strategies for social marketing of condoms developed for each state No. of sensitization meetings organized monthly No. of life skills

			• Introduce health promotion and nutrition education • Life Skills Education/promote safe sex behaviour among youth and adolescents, especially in tribal areas • Train local youth as peer educators		programmes organized in schools and communities

CONVERGENCE (PUBLIC PRIVATE PARTNERSHIP)

Objectives	**Actions to be undertaken**	**Agencies that can effectively undertake activities**	**Implementation Process**	**Time duration and the frequency of the activities to be undertaken**	**Possible monitoring mechanisms/ indicators**
Work with development partners and public and private sector enterprises to improve HIV/AIDS prevention and control in tribal people	Ensure public private partnership for IEC,BCC and Prevention strategies	• NACO/SACS	• Encourage private sector partnership for o Promotion of condoms o Mobile vans o Referral services o Adoption of ICTCs o Training of medical staff o Use of electronic media in media dark areas	Ongoing	Number of facilities effectively operationalised under PPP

Chapter 1

INTRODUCTION

1.1 BACKGROUND

The National AIDS Control Programme (NACP) Phase III aims to go beyond the high risk behavior groups covered by Targeted Interventions. This would entail extension of interventions to populations that are vulnerable to HIV such as the Tribal people and socially disadvantaged sections of the population in both rural and urban areas. A rural risk/vulnerability assessment has already been carried out; the present assessment has focused and limited itself to the assessment of tribal people only.

The HIV/AIDS can be effectively prevented only if the deep rooted values and attitudes that drive the risk behavior fuelling the epidemic are changed to understand the risk and vulnerability and thereby resulting in adoption of safe behaviors both sexual and health seeking. The social assessment of HIV/AIDS among tribal people is therefore considered as an essential requirement and a major tool for understanding the behaviors, practices that drive the vulnerability and risk among the tribal people. The assessment findings would guide evidence based design of HIV/AIDS prevention, diagnosis, treatment and care programs oriented towards this target population. It is expected also to improve understanding of the social dynamics underlying the transmission and management of HIV/AIDS in order to mitigate risks and scale up the programme effectively.

Tribal people of the country have poor health generally due to, among other factors, their poverty and social vulnerability. Tribal people are known to have sexual practices that differ from those of mainstream cultures, and a high prevalence of sexually transmitted infections. Less or nothing is known about the prevalence of STD/HIV/AIDS among them, except perhaps in some of the tribal states of the North-East that are among the NACP's priority states on account of the prevalence of drug use[6].

The World Bank policy on indigenous/tribal peoples, "**OP/BP 4.10, Indigenous Peoples**, underscores the need for Borrowers and Bank staff to identify indigenous peoples, consult with them, ensure that they participate in, and benefit from Bank-funded operations in a culturally appropriate way - and that adverse impacts on them are avoided, or where not feasible, minimized or mitigated".

With this background, the social assessment (SA) was conducted including review of the relevant literature and primary assessment among tribal people by **ORG Centre for Social Research (ORGCSR)** in selected states of country.

[6] NACO (2005) :TOR for Social Assessment of NACP Arrangements: 2

1.2 SPECIFIC OBJECTIVES

The specific objectives of the present assignment were to:

- To undertake a comprehensive SA that documents the prevalence and risk of HIV/AIDS among tribal people, their levels of knowledge, social and behavioural causes and consequences of HIV/AIDS (including stigma), and strategies used for PDTC of HIV/AIDS in order to ensure appropriate programme design and implementation to reduce the spread of HIV/AIDS and improve its management.
- To provide a mechanism for pre-project stakeholder consultations and to design continuous stakeholder consultations in the programme.

1.3 ASSESSMENT METHOD

The assessment was a qualitative research and the information was collected through;

- Review of literature
- Primary assessment among tribal people; and programme implementers and service providers

The relevant literature (including previous study reports, research papers etc) was reviewed to analyze information on tribal groups, National AIDS programme, HIV/AIDS policy and institutional (both private and public) arrangements. Most of these studies /research papers were prepared under the auspices of NACO, UNAIDS, RCSHA, FHI, NGOs and academicians. Besides website material, the studies conducted by ORGCSR in the area of HIV/AIDS were also reviewed. Reports and documents were also gathered from the assessment states and the districts. The review looked at both the community as well as the programme perspective to benefit the programme.

The primary SA was carried out among both primary stakeholders (beneficiaries) as well as the secondary stakeholders (implementing agencies/NGOs, service providers etc.) through an interactive process to understand the **social factors,** which might affect the NACP-III. Here, the primary stakeholders included tribal people and the secondary stakeholders included officials of State and District AIDS Control Societies, NGOs, STI specialists, private practitioners, traditional healers, community leaders and academicians. 30 FGDs and 60 IDIs (In-depth Interviews) were conducted with the primary stakeholders (i.e. tribal people). Participatory Rural appraisal (PRA) techniques like social mapping and chapatti diagramme were also used to understand the local dynamics in each of the tribal selected villages. Besides this, 57 IDIs with implementers/service providers/academicians were also conducted.

1.4 PRIMARY ASSESSMENT AREA

At the planning stage it was decided that this assignment be primarily a tribal assessment in high risk states or the states neighbouring to high risk states or the states considered vulnerable due to influx and out flux of migrants. Another criterion was that the state should have considerable tribal population. One district per state was selected. The same criteria were followed for selection of the districts. With this in view, **Chhattisgarh (Raipur)** and **Rajasthan (Dungarpur)** in the North;

Andhra Pradesh (Visakhapatnam) in the South; **Maharashtra (Thane)** in the West; and **West Bengal (Purulia) and Manipur (Churachandpur)** in the East/North East Zone were chosen for the primary assessment.

Villages with considerable tribal population and where from large number of people particularly males migrate temporarily to neighboring high risk districts/cities or falling on the National Highways and where at least one tribal PLWHA/STI was present as per the records maintained by the DACS/VCTC functioning at the selected district hospital were selected purposively. In each selected village, married male and female (25-49 age groups) and unmarried male and female (15-24 age group) were selected purposively for group discussion and one to one interviews.

It is important to note that the selection was purposive at all stages, therefore, the findings should not be interpreted as the representative of larger population. The findings are just indicative of certain situations from which one can derive ideas, lessons etc.

Detailed methodology comprising research tasks, selection procedures, operational aspects of the primary assessment and consultations, number of interviews conduced by states and limitations has been presented in Annexure 2.1-2.2.

1.5 REPORT STRUCTURE

Keeping in mind the suggested SA report structure, the chapterization plan and analysis plan were prepared. After having discussed the chapterization as well as the analysis plan in detail with NACP-III team, and obtaining consent, the qualitative data was analyzed in line with the suggested analysis plan. The report comprises of seven chapters. An executive summary is presented in the beginning of the report. The report presents the findings of the primary and secondary information in detail. The literature reviewed has also been integrated with the primary survey findings in the appropriate sections. The format of the report is as follows:

- Executive Summary and Tribal Action Plan
- Chapter 1: Introduction
- Chapter II: Description of NACP
- Chapter III: Basic Information on Tribal Communities and HIV/AIDS
- Chapter IV: Policy and Legal Framework
- Chapter V: Institutional Framework
- Chapter VI: Recommendations

Chapter 2

REVIEW OF SOCIAL DIMENSIONS OF HIV/AIDS AND SOCIAL GROUPS

2.1 Socio-economic and cultural dimensions of HIV/AIDS

HIV/AIDS is a social disease that can only be fought with deep-seated changes in behaviour, attitude and values. **Larger social issues** invoved with HIV/AIDS includes that the primary cause of STIs and STDs is man's polygamous behaviour and associated promiscuity. As a consequence were born the institution of prostitution, extra-marital and pre-marital sex affairs, infidelity, adultery, sexual harassment, rape and other sex crimes, etc. Prostitution has become a lucrative business; poverty is driving unfortunate women into this trade. Unscrupulous persons are illegally luring, abducting, forcing and compelling young girls and women for their own benefits. Acts such as Act for Prevention of Immoral Traffic of Women and Children, etc., have failed because of several reasons, especially shoddy enforcement. Despite their best efforts, NGOs have found it very difficult to rescue and rehabilitate the unfortunate girls who were forced to submit but desire to quit.

Solution to these larger societal issues rests with political support, police and other enforcement authorities, citizens' pressure groups, NGOs and activists, social and women's welfare departments, school education, etc. The issues are far beyond the scope of the control of STDs.It is true that without any rapport, development and transparency in regard to benefits such as fulfillment of primary and special needs, the people will not give full cooperation and the preventive interventions may fail or not be sustained for long[7].

Social assessment was expected to uncover the social and behavioural cause of HIV/AIDS for various social groups. The prevailing **socio-cultural features** have both positive and negative roles in relation to HIV/AIDS in India. For example, girl's early age of marriage in many parts of India makes them biologicallly more vulnerable and Indian family system provides essential support for HIV positive members. Similarly the traditional value systems could form the basis of more effective methods of prevention and care. There are culturally defined beliefs and myths that have provided fertile ground for the formation of culturally conditioned beliefs regarding HIV/AIDS. For example- (1) Generall assessment is that sex is a taboo subject which has an implication as misconception on sex and sexuality. (2) General assessment is that AIDS is not our problem which leads to lack of urgency reagarding the epidemic amongst people and policy makers[8].

[7] The International Workshop on AIDS Prevention and Care for People Affected by AIDS in India, organized under the Indo-Dutch Programme on Alternatives in Development (IDPAD), at the Royal Tropical Institute, Amsterdam, Netherlands, 27-29 June, 2001.
[8] UNESCO, 2002: A Cultural Approach to HIV/AIDS Prevetion and Care: Towards a handbook for India.

Similarly serious **socio-economic** unbalances amongst populations impacts heavily on vulnerability and risk in relation to HIV/AIDS. In this respect poverty, unemployement and lack of education are crucial aspects of the overall crisis which shapes the factual background to the disease**. Poverty** may lead to a kind of risk behviour or make people more vulnerable as far as HIV/AIDS is concerned. Poverty is directly related to nutritional status and health seeking behaviour. This is especially relavent with respect to STI. The poor in India have low nutritional status that makes them vulnerable to many type of infections due to deficiency of vitamin A and iron which affects the immune system. This makes them more vulnerable to STIs including HIV. The poor also have less access to health care and therefore, many of the STIs remains untreated. For many poor women, sex work is often the only means of earning a livelihood and maintaining the family. In these situations poor women become vulnerable to HIV/AIDS not only because they have multiple sex partners but also because they are unable to bargain for safe sex with their clients.

Thousands of young men migrate from rural to urban areas in earch of **employment** leaving their family behind very often. It has been found all over the World that circular migration has led to increase in the spread of HIV/AIDS. These youngmen in the absence of their wives often form partnership and relation ship with other women in urban areas. Umemployment may also lead to other tyoes of risk behaviour like substance use.

Education is often viewed as a panacea of all social and economic problems affecting a country. It is used as one of the indicators of social development. In a study undertaken in Delhi, it was found that years of schooling had a positive co-relation with knowledge about HIV/AIDS, partly because it was part of curriculum, although that did not mean an increase in the decision making power.

One of the prerequisites for good health is **access to health care**. Access to health includes three compoments- location acess, economic access and social access. A large number of people in India do not have acees to health due to above reasons. The studies have indicated that in some states like Orissa, UP etc, 60 percent of in-patients get treatment from government hospital both in urban and rural areas. Higher proportions of inpatients being treated by the public care system is not an indication its accessibility or its efficiency but is an indication of gross inadequacy of government health infrastructure in these states and it also indicates the poor development of private health infrastructure. High level of poverty and low incomes presumably restrict the demand for private health care. In comparison to rural areas, a slightly higher number of in patients are trated in public hospitals in the urban sector due to their easy locations. Factors, often catse based, present in local society may want health care diverted in a certain direction and might even prevent care from reaching others. With respect to **gender** unbalances, the burden of home care has always been on woman. The woman has the least access to health care, due to her low ststus in the marital family. This is related to both cultural reasons as well as unavailability of health services. The problem is compounded, re so in rural area, by the lack of female doctors whom women can visit. Also woman are accompanied by men to the doctor and she is unable to communicate her health problem openely. As a result she often resorts to self medication or traditional curative methods. Available studies in India indicate that HIV positive woman do not receive the same care and support as men. In many cases, the positive married married woman who husbands have died ogf HIVrelated illness are either turned out of their mrital homes or denied proper health care **Reproductive health issues** have a special significanace for HIV/AIDS in India, as heterosexual transmission is the most common route. HIV spread is more from man to

woman than vice versa. Also it is well known that efficacy of transmission increase when one or both partners are suffering from **STIs** due to open lesions and inflammations. Though a large scale data on STI is not available, but STIs emerged as important infections next to malaria and TB. Incidence is high but women report less at STD clinic due to social taboos and non-availability of user friendly services. Studies also show that 40-60% of patients visiting STD clinics in various parts of India reportedly got infection from sex workers whio suffer from 1-3 STI symptoms. They lack knowledge on care and prevention of STIs and also not able to bargain condom use with the client. Reasons for such a high incidence of STIs include ignorance of general population about the causes and symptoms, treatment and diagnostic facilities[9].

The other social dimensions of HIV/AIDS includes the public's attitude to the disease, the social stigma attached to it, social responses of fear, anxiety, denial and stigma, discrimination by doctors refusing to treat, hospitals refusing to admit, schools expelling students, employers denying employment, insurance companies refusing to insure, disowning by the families and friends, have become literally nightmares for HIV positive cases and AIDS patients, not only in developing Countries, but also in the developed World.[10]

A number of **NGOs** have started providing support to people living with HIV/AIDS along with the community outeach programmes. But these NGOs providing health services are mostly located in urban areas, though there are several examples of successful referral systems in NGO sector. The number of STD clinics around the country needs to be increased, and the problem of STDs have to be integrated in to the reproductive health package. As a part of **government support**, NACO aims at establishing a comprehensicve multisectoral HIV/AIDS programme in the country that would prevent HIV transmission; decrease morbildity and mortality associated with HIV infections and; minimize the socio economic impact resulting from HIV/AIDS.

2.2 Premises of Social Assessment

With above in view, a tool like social asessment is required to uncover the social causes and consequences of epidemic which inturn necessitates to explore the various social groups in the society and to understand the social envioronment of these identified groups which are socially vulnerable or excluded and or vulnerable to HIV/AIDS due to such socio- economic and cultural factors. It is aso important to assess their level of knowledge about STI/HIV/AIDS and also to assess their risk behaviours. Apart from that, it is pertinent to know about the institutions providing HIV/AIDS services to these groups and the policy environment around these groups. Identifying gaps with respect to the reach of the programme to these social groups and measures to be taken for the same and developing indicators to measures the impact of intervetions are among the other componets of social assessment.

[9] UNESCO, 2002: A Cultural Approach to HIV/AIDS Prevetion and Care: Towards a handbook for India.
[10] Economic, political & social dimensions: Prospects of winning the war against AIDS - IIIThursday, May 29, 2003 08:00 IST: Dr M D Nairhttp://www.pharmabiz.com/article/detnews.asp?articleid=15873&sectionid=46

Hence, the basic premises of social assessment of **HIV/AIDS programme** comprise of the followings [11],[12],[13]

1. Identification of social groups
2. Assessment of stakeholders attitude
3. Assessment of institutions involved in service delivery
4. Development of monitoring indicators

2.2.1. Social groups

All societies are composed of diverse **social groups** that may be identified on the basis of socio-economic characteristics like gender, ethnicity, religion, culture, geography and economic characterstics. It is important to understand as to which of these social groups are vulnerable and what are the factors making them socially vulnerable. There are group of people in all societies who are systematically disadvantaged because they are discriminated against. Discriminations occurs at public institutions such as the legal sysytem or the education and health services, as well as in the household and in the community. These discriminated people face social exclusion. Government health policies often fail to reach socially exluded groups. But they may be reached by many ways e.g. by formulating policies that promote social inclusion and by improving their access to services. Some of these "socially vulnerable groups" or "disadvataged groups" or "socially excluded groups" on account of their socio-economic and cultural milieu conditions might be more vulnerable to HIV/AIDS than others[14]. They are unable to avail infrastructure facilities like those related to health, education and development schemes either due to factors such as nomadic life, difficult access etc. It is also important to understand the expectations, needs and contribution of these social groups with respect to prevention and control of HIV/AIDS in the country.

How did we address this component?

Social environments are very complex and diverse in nature, understanding them for all the social groups requires multi-disciplinary approach, time, patience, resources and a great deal of local knowledge and expertise. With this in view, in consultation with the client, it was decided that a detailed social assessment will be conducted among tribal people only using primary and secondary information (refer Chapter 4). However, a brief review will be presented for those social groups also that would be identified in the course of undertaking primary social assessment. Therefore, the social assessment team, during the discussion with state and district level government officials, NGO representatives, VCTC counsellors, STI specialists, academicians and community leaders, attempted to identify other social groups before narrowing down on seeking detailed information on tribal groups. The list of such social groups by states is given below.

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[11] A DFID Policy Paper 2005: Reducing poverty by tackling social exclusion:1

[12] Social analyisis source book 2003: Incorporating social dimensions in World Bank Funded Project

[13] Turning Bureaucrats into Warriors: A Generic Operations Manual, Preparing and Implementing Multi-Sector HIV-AIDS Programs In Africa (June 2004) 135-138
http://siteresources.worldbank.org/INTAFRREGTOPHIVAIDS/Resources/717089-1113860017576/GOM-Chapter24.pdf

[14] A DFID Policy paper 2005: Reducing poverty by tackling social exclusion: pg 1-2

Social Groups	Andhra Pradesh	Maharashtra	Manipur	Rajasthan	West Bengal	Chhattisgarh
Street children	✓			✓	✓	
Women				✓		
Migrants	✓	✓	✓	✓	✓	✓
Tourists	✓			✓		
Youth		✓		✓		
Orphans		✓				
Defence personnel		✓		✓		

SA was also expected to document the HIV prevalence rates by social groups. As has been reported by ICMR data on prevelance rates by these socials groups is not available as of today.

A brief review of literature available on some of these social groups have been given below:

Women

Various studies indicated that the key issues contributing to the vulnerability of women are alcoholism, risk factors associated with RTI/STIs, HIV/AIDS, cultural practices, decision making and gender, migration and sexual networking[15]. Infection rates among women are rising as are the number of cases of HIV positive infants. As in many other countries, unequal power relations and low status of women as expressed by limited access to human, financial and economic assets weakens women's ability to protect themselves and negotiate for safer sex.[16]

As mentioned in Rajasthan State PIP document for NACP-III, particularly women are more vulnerable to the contraction of HIV/AIDS due to various factors like low literacy level, limited access to health services, migration and exploitation related issues and other socio cultural practices like NATA system. As part of an increasing emphasis on gender issues in NFHS-II, in Rajasthan, only 41 percent women are involved in making decisions about their own health care and almost same proportion of them can decide independently how to spend the money that they earn. Women in Rajasthan tend to marry at an early age. Forty-nine percent of women age 15.19 are already married, including 11 percent who are married but *gauna* has yet to be performed.

Although the spread of HIV/AIDS is a major concern in India, the majority of women in Rajasthan (79 percent) have never even heard of AIDS. Among women who have heard of AIDS, 87 percent learned about the disease from television, 28 percent from radio, and 27 percent from newspapers/magazines, suggesting that the governments efforts to promote AIDS awareness through the electronic mass media and print media have achieved some success. However, given the low level of exposure to mass media in Rajasthan, AIDS programmes will have to find innovative ways of reaching women who are not exposed to mass media. Among women who have heard of AIDS, 41 percent do not know of any way to avoid infection. Survey results suggest that health personnel could play a much larger role in promoting AIDS awareness.

[15] Rajasthan state NACP-III: PIP Document 2005

[16] HIV/AIDS South Asia: India (2006): http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPHEANUT/EXTSAREGTOPHIVAIDS/0,,contentMDK:20288516~menuPK:568874~pagePK:34004173~piPK:34003707~theSitePK:496967,00.html

Young People

Vulnerability of Young people to HIV/AIDS

Existing vulnerabilities of young people are exacerbated by the HIV/AIDS epidemic with economic and social problems unleashing a vicious circular dynamic, adding to the risk factors for HIV infection.[17] Studies indicate that Young People are sexually active before marriage and outside of marriage, more than was previously thought, and boys are more sexually active than girls. Young people, both boys and girls, have very little information on sexuality and HIV / AIDS prevention. Girls have almost no information, and boys have misinformation. Almost 73% of young people carried misconceptions related to modes of transmission of HIV/AIDS[18].

Girls are 'doubly vulnerable' – one because they are girls and second, because many of them are in circumstances that place them at risk such as living on the street, in brothels, as orphans, as labourers and as children affected and infected by HIV. Lacking the power to negotiate safe sex, many young brides may be more vulnerable to HIV and STI than unmarried girls. These young mothers become part of the adult population and may not receive the benefits of efforts that could provide them with needed information and services.

Other young people, like street children, adolescent sex workers, orphans and migrants, are 'marginalized' from mainstream services and society and are thus even more vulnerable. Their poverty forces them to endure situations that put them at risk of unprotected sex and substance use. An increase in the number of street and working children over the last decade reflects the emerging AIDS crisis. Children born to women in the sex trade are also at high risk of HIV/AIDS. They live in a context in which they are vulnerable to exploitation and abuse. Vulnerability of children and women is also aggravated by the demand for, and the selling of, younger girls for the sex trade.

Need for communication

Adolescence is the time in life when a person has many questions and hardly gets any straight answers, especially if the questions are about the changes in the body, the new feelings experienced and especially anything to do with sex. There is an unwillingness to accept that children and adolescents should know about sex and sexuality. Usually there is a public uproar or objection by parents and teachers when sex education is introduced or if children have to be taught about condoms. Neither is sex education available for children out of school or in state institutions.

The adolescents of today grow up in an environment that surround them with mixed messages about sex, drug use, alcohol, adolescent pregnancy, etc. Studies have shown repeatedly that young people have many misconceptions – for example many young people in India believe that HIV can be caused by a mosquito bite[19]. The media has played a significant role in promoting a lifestyle that draws no distinction between adolescence and adulthood. Consumerism-driven

[17] Mehta, M, The HIV/AIDS Crisis in India, South Asia Monitor CSIS No. 58 May 2003 www.csis.org
[18] NACO, 2001, Disaggregated data from National BSS: KAP of Young Adults (15-24 years)
[19] Young People and HIV: Opportunity in Crisis. 2002. UNICEF/UNAIDS/WHO

advertising has contributed its own share. However, when it comes to communicating with children and the young adults on these issues especially those related to sexuality, people hesitate. Many older people seem unwilling to discuss these things openly. The person then puts together the pieces of information that they get from the friends or the TV or magazines or the currently most popular medium of Internet or rely on imagination. This mixed information then forms the basis for making choices for all actions. For adolescents as for adults these choices are extremely complex. The problem is that adolescents are considered not to have enough or accurate information/knowledge, practice, skill, or facility to make accurate, safe choices.

Even if young people have the information they need, they may find it impossible to take appropriate action to protect them unless appropriate programmes and services are available to them. Hence the need of the hour is not only to help them accessing appropriate information but also to empower them and build emotional intelligence by enabling them to do what they know is right and to do it at the right time. When young people receive knowledge on inter-related issues they are in a better position to make wise choices.

Young people are very diverse and there are no 'one size fit all' approaches. Strategies to reach them must correspond to their life situations (married or unmarried; out of school or in school; employed or not; at special risk; HIV affected and infected).[20] Because young people have a unique identity, it would be wrong to plan mass programs that ignore the diverse realities young people live in. This means that services need to be tailored to different needs such as contraceptive supplies to unmarried youth, delaying child-bearing among the newly married, young people seeking treatment for STDs, HIV information and life skills for street youth. Also, accurate information provided at the right age delays onset of sexual activity and encourages responsible behaviour.[21]

All the above calls for conducting needs assessment at the time of planning programme for youth. As this population segment is in transition stage, their needs vary. A programme for 10 year olds is very different from that of 15 year olds not just in content but in the way issues have to be approached. Similarly programs for in school and out of school or rural and urban young people cannot be the same. The reality of a street child and that of a child growing up in institutions is very different. Programs must be adaptable to meet these needs.[22] Young people's needs go beyond sexual and reproductive health and include concerns about marriage, employment, schooling that play an equal and important role in their lives. The programme planners need to recognize this multiplicity of concerns and design programs more holistically.[23]

[20] UNFPA, State of the World's Population, 2003
[21] International HIV/AIDS Alliance. 2004. A Parrot on Your Shoulder. UK: International HIV/AIDS Alliance.
[22] Sonal Zaveri (2004): Addressing Sexual and Reproductive Health Issues of Young People in India: Ethical and Guiding Principles for Policies
[23] Jejheebhoy, S, Sebastian. M. 2003.Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India, Regional Working Papers No. 18. India: Population Council
[24] Working Group Report for Design of NACP-III 2005-06 : 229-240

Current Response to young people

Our National AIDS Policy also advocates a multi-sectoral approach to combat the epidemic. It emphasizes that by mainstreaming youth related issues in HIV and reproductive health into a number of sectors, a more holistic, sustained and cost-effective approach is possible. Operationally this would require persons from different sectors to plan together. This approach is uncommon because most departments have worked in isolation although the young person is the same target audience. To avoid mixed messages (which can be especially detrimental to young persons) and better utilization of funds and human resources, it is recommended that working groups and committees work towards a more integrated approach. Youth concerns should be a shared responsibility not just that of the Department of Youth and Sports but of all departments, neither should reproductive health be the concern of the Dept. of Family Welfare alone or the concern regarding children's rights the domain of the Dept. of Woman and Child Development and the issue of HIV/AIDS, the sole responsibility of the National AIDS Control Organization.

There are already on the ground, which are collaborative efforts of various government departments such as School AIDS Education Programme; Universities Talk AIDS (UTA); ARSH and life skills interventions are being supported through NYKS, NSS and RGNIYD; National Youth Parliament; reaching youth through TIs, mainstreaming young people in vulnerable communities through VTA and NGO outreach; initiation of district-wide strategy to reach young people in vulnerable communities in the high prevalence/high priority districts (NACO/SACS/UNICEF); nation, state and district wide mass media campaigns; Red Ribbon Express; Adolescent Reproductive and Sexual Health (ARSH) in the RCH - II Programme; etc. There are many other programmes at the planning stage.[24]

In the last half a decade, there has been a phenomenal growth in the numbers of NGOs mainstreaming HIV/AIDS into their programmes with varying focus. NGOs' work has touched every segment of the youth population, with varied scale of reach. NGOs – international, national and local – have not only implemented programmes individually but now they are building programmes in collaboration and partnerships for reaching out to larger and more unreached segments of youth population. NGOs have focussed largely on reaching out to the 'difficult to reach' subsets of population of women, affected and vulnerable children and young people in vulnerable settings.

Multiple types of interventions and approaches are being implemented in India. A number of international, national, and local organizations including USAID/IMPACT and India HIV/AIDS Alliance have supported efforts focusing on care and support for children affected by HIV/AIDS and prevention among children who are especially vulnerable to becoming infected by HIV/AIDS. There has been a significant involvement of private sector also in raising awareness and self esteem of people affected by HIV/AIDS.

Orphans

With regard to orphans, it is mentioned in the Manipur PIP document that there are 1504 children registered as orphans of that 691 are infected by HIV/AIDS. But the figure is believed to be just a tip of an iceberg. These children need not only medical but also social and economic support. Many of them are deprived of school facility as well as good nutritious food due to financial constraints. To set a baseline for children orphaned/affected by HIV/AIDS is a high priority for effectively achieving the goal of NACP III. Now the epidemic is almost one and half decade old and many have already succumbed and we are witnessing an increasing number of widows and orphans.[25]

Tourists

Tourism plays an increasingly important role for India and is the country's second largest source of foreign currency. More than 5 million Indians are employed by the tourism industry, and 12 million are indirectly dependent on it. Further development of the tourism sector is planned. Individual tourism and package tourism are equally important. Above all Western Europeans, North Americans, and Australians come to India for its varied cultural and religious monuments, as well as for the wide beaches of Goa and the coastal areas in the east, west and south of the country. In 2000, 2.5 million guests came to India. In recent years bars and discotheques have opened up, in part as a result of growing tourism. In connection with this, there has also been a growth of sex trade and cases of trafficking in humans.

The tourists are at particular risk from the pandemic of HIV/AIDS because they live away from family and tend to practice more risky behaviour in terms of unsafe sex and substance use (alcohol, drug etc). Loneliness, boredom, and a sense of freedom contribute to this behavioral change. Some of the news in major newspapers around the world which enforces the fact of ever increasing sex at tourist places aross India are:

- At least 2,000 women are in sex work along the Baina beachfront in Goa.[26]
- Foreign tourists are frequenting India because of its relaxed laws, abundant child sex workers and the false idea that there is a lower incidence of AIDS. [27]
- India is one of the favored destinations of pedophile sex tourists from Europe and the United States. [28]
- In 1990 an orphanage owner in Goa was arrested for allegedly supplying children to British, French, German, Swiss and Scandinavian tourists for sex [29]
- The main frequenters of sex workers in Goa are tourists, local men and college boys. Taxi drivers take tourists from Delhi, Gujarat, Bangalore, Bombay and Punjab to brothels in Baina.[30]

[25] Manipur state PIP, NACP III, 2006-2011
[26] Frederick Moronha, India Abroad News Service, 9 August 1997)
[27] Rahul Bedi, "Bid To Protect Chedren As Sex Tourism Spreads," 1997
[28] Global law to punish sex tourists sought by Britain and EU," The Indian Express, 21 November 1997
[29] Rahul Bedi, "Bid To Protect Children As Sex Tourism Spreads, "London's Daily Telegraph, 1997

Rajasthan receives fair to heavy influx of foreigner as well as Indian tourists especially in winter. As reported by NGOs, tourists here get involved in sexual relationships with sex workers. Also it was reported that one can see many tourist in Jaiselmer who are male sex workers. Similarly in Andhra Pradesh it was reported that in tourist spots like Aruka Valley tourists indulge in sexual activities with young tribal girls.NACP-III must seek collaborations with or co-operation from Tourist Departments for minimizing the impct of epidemic among tourists.

Daughter of Sex Workers

The **daughters of sex workers** are reported as a group at risk in Rajasthan during primary social assessment. [31]

The children of sex workers are effectively all street children, as they have nowhere else to go but the city streets when their mothers are working. Girls on the street are inevitably the victims of sexual abuse and this often leads to a career in sex work. So, in addition to the pressures for these girls to enter sex work, that come from having a mother as a sex worker and living in a brothel, the girls are also faced with street life as a further factor to push them into sex work.[32]

For the daughter of a sex worker, orphanhood almost certainly means that she will have to enter commercial sex work. The mother's capability to keep the child out of sex work is limited by financial circumstances and the coercive nature of their employers. Orphans in the red light districts become the property of the brothel keepers, who have no use for them unless they are "working". Girls will inevitably take over their mother's trade. Without parents they are likely to take up this "work" at an earlier age than would otherwise have been the case for those who were doomed to follow their mothers anyway.

Interventions need to be started with them at an urget basis in the next phase of the programme.

Defense personnel

Military personnel are a population group at special risk of exposure to STIs, including HIV. STI rates among armed forces are generally two-to-five times higher than in civilian populations. Probably the single most important factor leading to high rates of HIV in the military is the practice of posting personnel far from their communities and families for varying periods of time. Freedom

[30] Menon, Meena: "Tourism and Prostitution, "The Hindu 1997

[31] Rajasthan state NACP-III: PIP Document 2005

[32] Association Francois-Xavier Bagnoud Report : Orphan Alert 2: Children of HIV/AIDS pandemic – The challenge for India;. http://www.albinasactionfororphans.org/learn/ORPHANALERT2.pdf

from social and traditional controls removes them from contact with spouses or regular sexual partners and thereby encourages the growth of sex industries in the areas where they are posted.[33] There are evidences that the sex work industry thrives in the adjoining areas to the armed forces bases.[34]

According to a study on assessment of prevalence of HIV infection in central police and paramilitary forces of India[35] (Calcutta, Dhanbad, Imphal, Hyderabad, Dehradun), military and paramilitary forces are one of the vulnerable groups. Awareness regarding HIV/AIDS was quite high among the troops, but awareness regarding sexually transmitted infections was not adequate. In spite of this, behavior patterns indicate a propensity for risky behavior. Condom availability was easy for only about half of the respondents. Even if these were adequately available, there was reluctance in obtaining condoms from the hospital in front of senior staff.

PLWAs are highly discriminated, including senior officials. There is stigma among personnel to tested. No separate clinics were found for STD/HIV/AIDS in any of the sector/zonal/base hospitals the paramilitary forces. Most of the sector/base hospitals do not have standardized rapid/ confirmat test kits for HIV neither was there a systematic blood testing system for HIV/AIDS. IEC material w not available in local languages, which acts as a constraint disseminating knowledge about HIV/AI to the target audience. Findings of the assessment also indicated that except for BSF, a majority of personnel of all forces were in favour of separate care centres for HIV/AIDS infected persons. T CISF personnel were most reluctant to share food with HIV/AIDS infected persons. A signific proportion of ITBP personnel were in favour of isolation of HIV/AIDS cases as compared to the forc Discrimination against HIV positive personnel prevailed in general. Majority of personnel use condo for family planning rather than as a protective measure against HIV/AIDS.

No medical facilities were available for infected personnel, including ARVs, not even basic in-hou medical facilities. No training is imparted to barbers employed in the battalions to adopt saf precautions to prevent possibility of transmission through use of infected scissors/ blades, etc. Medi officers too lack systematic training about HIV/AIDS/STD. The assessment indicated that inforr arrangements for networking/ coordination would not be effective for any programme for the forc There is need for an organized system of surveillance based on blood testing, either compulsory voluntary. Institutionalization and validation of procedures for rapid and confirmatory tests a compulsory blood tests in asymptomatic cases is required.

Co-ordination between NACP and the forces is strongly recommended. Regular detection of H among these forces is important to determine the burden of the infection on a regular basis. At same time, sensitizing senior staff towards HIV/AIDS, rigorous dissemination of IEC material, provis of infrastructure- especially medical and organizational, supply of condoms, identifying NGOs wh could be networked with to provide care and support. A regular follow up and exchange of informat between the military hospitals and SACS is required to proceed in this direction.

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[33] IPPF Advocady Guide for HIV/AIDS (2001) :
http://www2.eastwestcenter.org/research/popcomm/pdf/IPPF_HIV_AIDS_Advocacy.pdf
[34]ORG-MARG Report (1995) : Migratory Populations of Western Rajasthan : 1-8
[35] NACO Report (2005): Assessment of Extent of HIV/AIDS Prevalence among Central Police and Paramilitary Forces

2.2.2 Assessment of stakeholders attitude

Since the assesment was primarily conducted among tribal people, the tribal people stakeholders' knowledge, attitude and practices regarding HIV/ AIDS, programme facilities and services were assessed. The findings of assesment have been presented in Chapter 4. It was also important to understand their level of interaction with the high risk core groups (Female sex workers, MSM and IDUs). Above understanding about the tribal people would help develop indicators to assess the effectiveness of proposed interventions after implementaion of NACP in the proposed area.

2.2.3 Institutions around the programme

Important institutions (formal and informal) that are to be involved in the implementation of NACP among tribal people were assessed interms of type of reporting units, coverage of TIs across urban and rural/tribal areas; need of expanding activities to these areas; feasibility of expanding interventions, need for tribal specific interventions and need to provide interventions for mobile population; policy and laws implications affecting accessibility to these institutions (for details refer Chapter 5).

These institutions included State AIDS Control Societies (SACS), District level Institutions or reporting units (like PMO/DMHO, VCTC, STI clinics) and NGOs. Village level institutions/personnel (Sarpanch, ANM, Youth Group, Mahila Mandal, Private Doctor, PHC etc) identified by the community as influential and important personnel and institutions. The details on institutional assessment have been given in Chapter 6.

Annexure 3.1- 3.6 presents some factual information about the state programmes on number of STD clinics, VCTCs, Surveillance sites, care and support centres, and HIV prevalence rates in the selected state/district.

2.2.4 Development of Monitoring indicators

As intended by this component, based on the gaps identified during social assessment of HIV/AIDS among tribal people in India and the suggestive actions, a set of monitoring indicators have been suggested in the tribal action plan.

Chapter 3

HIV/AIDS AMONG TRIBAL PEOPLE

India has the second largest concentration of tribals in the World. Indian tribes constitute around 8.2 percent of nation's total population, constituting nearly 84.3 million according to Census 2001.[36] There are 635 tribes in India located in five major tribal belts across the country. Seven Indian states account for more than 75 percent of the tribal population. The main concentration of tribal people is the central tribal belt in the middle part of the India and in the north-eastern States. However, they have their presence in all States and Union Territories except the State of Haryana, Punjab, Delhi and Chandigarh. The predominantly tribal-populated States of the country (tribal population more than 50% of the total population) are: Arunachal Pradesh, Meghalaya, Mizoram, Nagaland and Union Territories of Dadra & Nagar Haveli and Lakshadweep (IDSP 2003). The prominent tribal areas constitute about 15 percent of the total geographical area of the country and correspond largely to under developed areas of the country (IDSP 2003).[37]

Tribal communities of India, though very close knit society, cannot be clubbed together as one homogeneous group. They belong to different ethno-lingual groups, profess diverse faith and are at varied/different levels of development- economically, educationally and culturally. Over the years, displacement and rapid acculturation of this population has led to changes in their socio-cultural and value systems.

Tribals have poor access to health services and there is also under utilization of health services owing to social, cultural and economic factors. Some of the problems of accessibility and poor utilization of health services unique to tribal areas are because of difficult terrain and sparsely distributed tribal population in forests and hilly regions; locational disadvantage of sub-centers, PHCs, CHCs; non availability of service providers due to vacant posts and lack of residential facilities; lack of suitable transport facility for quick referral of emergency cases; lack of appropriate HRD policy to encourage/motivate the service providers to work in tribal areas; inadequate mobilization of NGOs; lack of integration with other health programs and other development sectors; IEC activities not tuned to the tribal: idioms, beliefs and practices; services not being client friendly in terms of timing, cultural barriers inhibiting utilization; non involvement of the local traditional faith healers and weak monitoring and supervision systems.[38]

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[36] Lokpriy (2004-05): Demographic Profile Scheduled Tribes In India, 1981-2001, *Seminar Paper submitted as a part of requirement for Diploma Course in Population Studies, during the year 2004-05,* International Institute for Population Sciences, Deonar, Mumbai,: 7

[37] Central TB Division, Directorate General of Health services, MoHFW (2005): Revised National Tuberculosis Control Programme, Tribal Action Plan (Proposed for the World Bank assisted RNTCP II Project):1 http://www.tbcindia.org/pdfs/RNTCP%20II%20Tribal%20Action%20Plan_10th%20May%2005.pdf

[38] Department of Family Welfare, MoHFW, GOI (2004): Project Implementation Plan for Vulnerable Groups Under RCH II: 11 http://mohfw.nic.in/VOLUNERABLE%20COMMUNITIES%20MODIFIED.pdf

Due to poor health infrastructure, high levels of poverty and ignorance, tribal communities are highly vulnerable to various health problems, especially, communicable diseases including HIV/AIDS. The awareness level of tribal people specifically with regard to HIV/AIDS has been low. Only 17 percent of women belonging to scheduled tribe had heard about AIDS compared to 32 percent of SC, 42 percent OBC and 48 percent of women from other castes.[39] There is, therefore, a need for designing interventions specifically to curtail the increasing threat of HIV and other STDs among these vulnerable populations. There is no specific information available regarding the prevalence of HIV/AIDS among tribal people. However, an attempt towards exploring such information indicated that 12 percent of the districts with > 50% ST population have been faling in high prevalence category. (Refer annexure 4.3).

Annexure 4.1 and 4.2 present profile of primary assessment area and socio economic profile of tribal

3.1 Socio-Cultural Profile of Tribal People

Impressive details on the customs of the tribals have been presented in the studies conducted in the past.[40] [41] These studies reveal that customs like the institution of marriage, age at marriage, separation, sexual practices, opportunities made available to youth to mix with opposite sexes such as melas, fairs etc. vary from tribe to tribe. Some of the early research on sexuality in India conducted by Verrier Elwin makes it evident that there was considerably more sexual freedom, and less male dominance in sexual and marital relationships amongst tribal communities. (Elwin 1964) It was also made evident that tribal groups had varied sexual practices, and in some of them the sexual patterns were just as strict as in non-tribal communities. He described the 'village dormitories' or 'ghotul' in which youth lived and slept together[42]. In his autobiography Elwin wrote:

> "At least at the time I knew them, the Murias had a simple, innocent and natural attitude to sex. In the ghotul this was strengthened by the absence of any sense of guilt and the general freedom from external interference. The Murias believed that sexual congress was a good thing; it did you good; it was healthy and beautiful; when performed by the right people, at the right time and in the right place, it was the happiest and best thing in life."

The tribal communities covered in the six states also followed different and interesting customs. With regard to marriage, the customs varied from state to state. The age at marriage ranged from 15-18 for girls and 18-21 for boys. A micro-level study, which dealt with the age at marriage of individual tribes, also reported similar range. [43] [44] In some states the customs were strict as in non-

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[39] National Family Health Survey-2 (1998-99), International Institute of Population Sciences; 230
[40] Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Priliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal, Chapter 5: 1-9
[41] Basu, S K (1993): Health Status of Tribal Women in India, NIHFW: 3
http://www.hsph.harvard.edu/grhf-asia/forums/Tribals/Tribals/M002.HTM
[42] Verma et. al (2004): Sexuality in the Times of AIDS, Contemporary Perspectives from Communities in India: 346-347
[43] DJWINFO, This wants me to cry (2005) http://djwinfo.blogspot.com/2005/01/this-makes-me-want-to-cry.html: 1
[44] Basu, S K (1993): Health Status of Tribal Women in India, NIHFW: 3

tribal communities like arranged marriage by parents (Rajasthan and Chattisgarh); in some states the tribal communities reported live-in relationships/starting a family before marriage mainly due to economic compulsion (West Bengal and Maharashtra); marriages were performed by negotiations, capture, love, and even elopement (Andhra Pradesh); and In Manipur since all the tribal societies are Christians, both arranged and love marriages were common. Women had the choice of divorce and remarry and in many societies; bride price (*lagan* called in Rajasthan, *moganali in Andhra Pradesh*) had to be paid by the bridegroom. Interestingly, dowry system was reported to be on the decline and they practiced a form of monogamy in which they changed partners and remarried. In Maharashtra sexual relationships before marriage were also acceptable, but not outside marriage, thus practicing monogamy. Among tribal people, cross-cousin marriages were also preferred and practiced. Customs which espoused safety for the widowed women like *Natha pratha* (marriage to husband's brother) and *Ana Karna* (re-marriage) were prevalent in Rajasthan. Divorce was socially accepted and could be initiated from either side. A new tradition of group marriages (*samuhik vivah)* was promoted by NGOs and voluntary workers in Maharashtra. Major focus of these gatherings was to legalize childbirth and provide a status to the women in the community.

Financial independence was considered to be of utmost importance in most of the tribal societies. A study reported that the timing of the marriage depends on the ability of the couple to institute an independent economic unit. This is further confirmed by the boy's anxiety to separate from the father's house soon after the wedding and the building of a new house in the neighborhood (Aurora, 1972)[45]

Melas/fairs/dances were an integral part of the tribal societies in most of the states (*mela, Beneshwar mela, Leelapani mela, Shamlaji mela in Rajasthan; Chhau dance and Santhal in West Bengal; Dimsa dance in Andhra Pradesh)* and these were the places where they got attracted to each other or the relationships between girls and boys generally developed.

It was also observed that since tribals interact with outside people, they have been greatly influenced by them. This interaction happens during melas/fairs and also as a result of exploring employment opportunities and due to acute poverty. Although generalizations can not be made due to scant literature, based on the available information it can be said that to some extent these interactions have created space for HIV vulnerability among young tribal. A study listed several causes for the vulnerability of tribals to STIs. It found that in the prevalent institution of bride price if the boys from the communities are unable to pay the bride price, then girls are offered in marriage to non-tribals like truckers, contractors, forest contractors etc. While the unsuspecting tribals consider this union as marriage, those marrying the girls consider this as fun and often leave the girl after the sexual union. Another system called Dormitories' that is prevalent and varies from tribe to tribes is being misutilised in some cases and is used as brothels.[46] Further exploratory studies are needed to this effect, based on which measures can be initiated to generate awareness.

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http://www.hsph.harvard.edu/grhf-asia/forums/Tribals/Tribals/M002.HTM

[45] Gandotra, M.M. et. al (2001), Population Research Centre, MS. Univerirty , Baroda: The Demography of tribal population in Western India; 7 http://www.iussp.org/Brazil2001/s40/S48_P08_Gandotra.pdf

[46]Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Priliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal, Chapter 5: 1-9

3.2 Media Habits of Tribals

As is known access to media is limited in the rural areas of our country, especially in the tribal areas. NFHS-2 reported ownership of radio in rural areas at 32 percent and to TV at only 21 percent.[47] However, the national level data on listenership and viewership of radio and TV revealed that people in rural areas had higher reach than the ownership (Radio: 40%, range: 15-77%, TV: 58% range 23-86%).[48]

The visits to tribal areas also revealed that among the states covered, though access to radio and TV was reported in Maharashtra, Rajasthan, Andhra Pradesh and Chattisgarh, the communities in West Bengal and Manipur could not afford to have Radio and TV. Irrespective of the accessibility of these mediums, all the tribal communities expressed their attraction towards TV. Among these electronic mediums, radio was more popular than TV. Women had less access to both the mediums as compared to men. There were factors like non-availablity of electricity, which resulted in low access. Access to print media was minimal. This was mainly due to low levels of literacy.

In **Rajasthan** it was found that men read newspaper at the time of visit to the Panchayat Samiti, which they get from any teashop or dhaba. Discussions also revealed that the tribal people are fond of watching movies and often men visited cinema halls. Women, especially those married did not have access to any kind of media. The sources of information for them were friends, relatives, Anganwadi workers, ANMs and school teachers.

In the villages of **West Bengal** although the tribal people expressed their strong liking for TV, there were some who had never seen a television in their life. Generally people loved watching movies, serials, songs and tribal programmes on the television. As far as newspaper was concerned, there were hardly few literate people who could read newspapers.

In **Chhattisgarh** the tribal communities covered across the villages slightly differed from each other. The tribals of Kochvay village of Gariaband, Behradih village of Mainpur block, Kulhadighat villages of Mainpur block mostly depended on inter personal communication. Here, the channels of information were school teachers, health functionaries, village leaders and people visiting block headquarters or other places. Very few houses including the Panchayat Bhavan had television with Doordarshan and cable connections. In Semra and Piprahi villages of Churra block, television was found to be the major source of information followed by newspaper. The most commonly watched serials were "*Jasoos Vijay*" and "*Hallo* Kalyani", which provided major information on HIV/AIDS.

In **Andhra Pradesh**, the tribes visited had access to most forms of media i.e. TV, newspaper, magazine, radio and movies. Most preferred media was TV. The men were interested in news items, whereas women were interested in serials and news. Television was connected to Doordarshan but not to satellite channels. The community members even saw movies frequently

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[47] National Family Health Survey-2 (1998-99), International Institute of Population Sciences; 1 http://www.nfhsindia.org/data/india/keyfind.pdf

[48] NACO (2001): Baseline Behavioral Surveillanve Survey among General Population: 61-62

by hiring VCR and CD players rather than going to cinema halls. The educated people also read newspapers and magazines.

The tribal communities in **Manipur** were not prosperous enough to have television, though some of the houses in two of the villages did report having televisions. But almost every household possessed a radio. In all the five study villages, the community had access to newspaper and radio. Mostly evening programmes between 4.30 – 6.30 pm were heard. The common radio programmes heard were those which tribals related most to and agriculture based. The most commonly watched channels in the two villages having access to TV were reported to be HBO, ESPN, and NDTV. Some of the FGDs and in-depth discussions revealed that radio and drama were used as a source of entertainment. Interpersonal communication by NGO volunteers and friends were another common source of health related information, especially HIV/AIDS.

In the communities visited in **Maharashtra** television and radio were the only two modes of entertainment. In some of the villages that had closer ties with urban areas, both television and radio were easily available and accessible. But in some places only a few households possessed such luxuries. The younger age group was mostly television savvy. They watched TV during evenings for about half an hour or an hour, since they had to go to school during mornings. Mostly news and music was listened to on radio. Newspapers were read mostly by the educated set of people.

The above discussion indicates that the communication efforts in tribal areas have to have a mix of media forms such as mass media, print media and IPC. TV though liked strongly does not seem to be viable for these hard to reach areas. Non-availability/inadequate electricity supply and low access of radio/TV for women are the main causes. Several community level participatory and empowering tools such as IPC, Peer Education, Community radio, folk media youth clubs need to be explored intensively. While doing so utilization of the persons considered important and influential[49] by tribals like panchayat members, ANM, AWW, school teachers, village priest need to be kept in mind. The use of persons considered influential and important

3.3 AWARENESS AND ATTITUDE TOWARDS GENERAL HEALTH ISSUES, STIs AND HEALTH SEEKING BEHAVIOR

3.3.1 Awareness of General Health Issues

Group discussions with the men and women across all the study areas revealed that they were aware of general health problems. The most prevalent diseases were malaria and tuberculosis. The other diseases known to them were - skin infections, leprosy, cough and cold and pneumonia; malnutrition, ARI and diarrhea among children; and anemia, malnutrition, white discharge among women.

Women in **Manipur** reported white discharge along with lower abdomen pain as highly prevalent in their villages. In Maharashtra other than the diseases mentioned above, Elephant legs (*filariasis*)

[49] Identified during visits to tribal areas using chapatti diagram (See Chapter 5)

were also quite common among the tribes. There were some misconceptions about malaria in these tribes as well.

TB was also considered to be a serious illness in **Maharashtra**. It was also mentioned that non-compliance to treatment can lead to aggravation of the illness and the person may ultimately die.

On the whole, spontaneous awareness of HIV/AIDS was low which indicates that the programme needs to scale up awareness efforts for tribal groups. Since the top of the mind health problems are other than HIV/AIDS, the NACP planners would have to suitably link up services with other national programmes.

3.3.2 Health Seeking Behavior for General Illnesses

The health-seeking pattern varied from state to state. Traditional healers in Rajasthan, home remedies in West Bengal, Chhattisgarh and Maharashtra, self-medication in Manipur were the first measures taken at the onset of the disease. Health workers, especially ANMs were the key persons providing health care in some states. The health workers or the facilities were visited only in cases when the patients did not get cured. However, in Andhra Pradesh, accessibility of the government health facility was detrimental in availing the services. If the services were available within the village or close to it, these were availed at the very onset of the disease. Other options like traditional healers, home remedies etc were tried only either after this treatment could not cure the disease or health facility was inaccessible due to long distance or lack of transportation. However, the younger generation preferred to go to health facilities in the initial stage itself. Private treatment was preferred to government treatment due to easier accessibility. Faith in traditional healers/ home remedies was the prime reasons why people resorted to them at the onset of disease. Poor accessibility of government health facilities, presence of numerous quacks and unqualified private practitioners at accessible locations and faith in traditional healers were the main concerns to be addressed for improving primary health care services. There were reports of the faith healers referring the cases to hospitals (public or private). All this indicates the need to involve private practitioners and traditional healers for providing referral services on one hand and scale up PDTC services on the other.

Review of literature has revealed that due to poverty, poor accessibility to health facilities and various socio-cultural beliefs, generally home remedies were resorted to by tribals, followed by treatment by traditional healers. In case of serious cases, however, patients were taken to hospital earlier.[50]. Around 71% of the tribals had faith in traditional healers, which they had inherited from their ancestors. They felt that traditional medicines are inexpensive and available at their doorsteps [51]

As regards decision-making with regard to seeking treatment, mainly the decision of the head of the household prevailed. This was true of other matters as well such as those related finance, education of children etc. Findings from the earlier studies though indicated mixed responses. One study observed that elders in the families influenced decisions regarding place, type and timing of

[50] Integrated Disease Suveillance Project, Tribal Development Plan (2002):6 http://mohfw.nic.in/TDP.pdf

[51] Mathiyazhagan, T. (2004) :A Pilot Study on Communication Strategy for Reaching the Unreached Tribal Population in Mandla district of Madhya Pradesh : 3

seeking health care especially in tribal areas, only in some cases like those in nuclear families, the role of both husband and wife was mentioned in taking joint decisions.[52] One study carried out in Bihar observed that Schedule tribe women are much more likely to be involved in household decision making than are women in any other social groups.[53] Women autonomy in tribals may be seen as a positive aspect of tribal culture to be capitalized while planning a programme.

Across all the study areas except Manipur it was seen that there existed gender biasness in seeking treatment. Though both male and female members of the family received treatment, the priority was always given to the male member. Some group discussions revealed that the gender differences were generally true for the married female members. Unmarried female members generally did get due attention with regard to treatment. Review of literature also revealed such gender discrimination with regard to health care. The findings reflected that when men fell sick prompt treatment was sought. In contrast, when women were sick they were taken to health care providers only if symptoms did not subside by home remedies. Women faced social, physical and economic barriers to seeking healthcare and are often seen to accord very low priority to their health needs.[54]

3.3.3 Awareness of STI Symptoms and Misconceptions

During the group discussions male as well as the female members were "shy" to talk about STI. Their knowledge regarding STIs was also low in all the states except for Manipur and to some extent in Maharashtra and Andhra Pradesh. Some of the stakeholders like the STI specialist, private doctors and NGOs mentioned that since STI was commonly found in the industrial areas, migrants and truckers, awareness was comparatively higher in these areas than in the tribal areas. In **Chattisgarh** some wall writings on STI were seen, which said *"STI can be prevented by using nirodh"*, which served as source of information. The wall writings were funded by the health department and the NGO under the "Chayan" programme of CARE that focuses on IEC activities. The males were relatively more open to talk about STI than the females. The discussions as well as consultations revealed that the commonly prevalent STIs among the tribal people were - trichomoniasis, gonorrhoea syphilis, herpes, vaginitis, UTI and stality with the symptoms, genital discharge, genital ulcer/sore, burning pain during urination, discharge of pus from uterus, vagina or penis ulcer etc.

STI was referred to as "*safed pani*" in most of study areas. In **Andhra Pradesh** it was referred to as '*Munda Jabbu'* and in **Maharashtra**, as "*Gupt Rog*". The male respondents mentioned that STIs occurred due to multiple partner sex and sex with commercial sex workers.

As an exception, in **Manipur**, the female and male respondents were highly aware of STI symptoms as well as the causes like- multiple and unprotected sex. It was further reported during consultations that the MSMs, IDUs and CSWs were highly aware of the symptoms and causes.

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[52] Integrated Disease Suveillance Project, Tribal Development Plan (2002):6 http://mohfw.nic.in/TDP.pdf
[53] National Family Health Survey-2, Bihar (1998-99), International Institute of Population Sciences; 48

[54] Integrated Disease Suveillance Project, Tribal Development Plan (2002):6 http://mohfw.nic.in/TDP.pdf

The higher level of awareness Churachandpur district (classified as high risk district) may be attributed to the IEC efforts of district level officials and NGOs in Churachandpur district.

Review of literature further substantiated that awareness of STDs was low i.e. less than a third of all respondents had heard of STDs in the entire country.[55] Another study conducted in southern part of the country amongst tribals revealed that most of the respondents had not heard of STDs, and of those who had heard of them only 1 percent was aware of associated symptoms.[56] However, in one of the study in Maharashtra, 49 percent of men and 59 percent of women were aware of STIs.[57]

Across all the study states occurrence of STI were generally not shared with others. Women generally ignored these types of problems until it became a serious problem. Also women ignored white discharge because they did not consider it as problem, but a natural phenomenon among women. Often they did not visit the health facility because of this. They either ignored the problem or adopted home remedies. Even if they visited the health facility, treatment was sought secretly.

Some of the misconceptions about STI that were prevalent in the tribal people were – STIs are caused due to eating spicy food, heat in the body, using public toilets, not maintaining hygiene during menstruation, or even by use of soap. The males believed that these problems basically originated in women, men only get infected through women. Whereas, the women believed that they get the problem from men who have multiple partner sex. In **Manipur** since the awareness levels were high, there were no misconceptions regarding STI.

These findings are corroborated with the findings of one of the studies carried out in the rural areas of Udaipur where more than 47 percent of the population was tribal. It found that most of the women thought pain or burning during urination and itchy genital area as a normal phenomenon and did not consult a doctor. It further found that RTI complications were a universal phenomenon as around 45 FGDs with females reported a high level of RTI problem. The women suffering from RTI/STI did not consult any physician unless the problem becomes very acute because of the stigma and shame associated with RTIs/STDs.[58] One of the papers analyzing the research in India indicates that poor women carry a heavy burden of reproductive morbidity; a significant component of such morbidity is due to reproductive tract infections, many of which are sexually transmitted; these reproductive illnesses among women are invisible because of the `culture of silence' that surrounds them; and women do not have access to health care for these illnesses.[59] The above discussion indicates that with the situation becoming more complex due the threat of spread of HIV, the programme would need to address the issue in a more focused manner, which lead to encouraging open discussions on RTIs/STIs, its identification and treatment with partner-treatment getting due attention.

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[55] NACO (2001): Behavioral Surveillanve Survey Among General Population: 60.

[56] Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109

[57] World Vision (1997) An Exploratory Study of Sexual Networking Patterns of Tribals, Navapur , Maharashtra: 13

[58] DoH&FW (M) Govt. of Rajasthan (2003) :District Strategic Plan, Udaipur : 7 http://www.youandaids.org/Charca/Resources/DSP%20Udaipur.pdf

[59] Saroj Pachauri (1999): Introductory Essay: Moving Towards Reproductive Health: Issues and Evidence, Implementing a Reproductive Health Agenda in India: The Beginning: 14 http://www.popcouncil.org/pdfs/implementing.pdf

3.3.4 Availability of STI Treatment Facilities and Health Seeking Behaviour

As mentioned earlier, though women were aware of the treatment facilities, they generally avoided treatment of the STIs, due to stigma. They, therefore, relied on home remedies or alternate systems of medicine like Unani, Ayurvedic and Homeopathy.

A study found that infections of the female genital tract were numerous and widespread. They constituted a large part of grade morbidity among women contributing to a continuous and physically draining fatigue. These infections were closely related to inappropriate care or poor hygiene in connection with childbirth abortion or menstruation. They included the sexually transmitted diseases, which were most prevalent diseases in the tribal areas. These infections were often untreated as they were difficult to diagnose and would even lead to infertility. [60]

Across all the states the group discussion revealed for STIs women often went to traditional healers, apart form discussing with ANM/*dai*. However, they also availed services at the CHC or PHC for STI. Those who availed these services mentioned that they were not satisfied with the services provided by these facilities, as they had to wait for hours to see a doctor. Some of them also added that there was no female doctor at the CHC because of which they hesitated to go to the hospital. The National BSS among General Population also substantiated these findings with less than 25% of respondents who had STD symptoms, not visiting a government facility for treatment. [61]

With regard to health seeking behaviour (including STI treatment), it was found that many people first rely on home remedies/self medication and also go to traditional healers. Similar findings have been reported in other studies.[62] This has been a general pattern of treatment seeking behaviour amongst the tribals for any health problem and need to be taken note of. Inclusion of traditional healers would have to be explored if tribal people are to be reached effectively.

3.3.5 Causes of their vulnerability to STIs

Across all the states it was revealed that migrants, mobile sex workers and clients of mobile sex workers, those with multiple sex partners perceived by NGOs, academicians, SACs and DACS officials to be more vulnerable to STI. The doctors interviewed added that the youth are more susceptible to STI due to lack awareness of safe sex practices. In Manipur, other than the above categories, the tribal people also mentioned that persons, who are IDUs, visit CSWs and maintain multiple partner relationships and army personnel are more vulnerable to STI. In Chhattisgarh the health providers were of the opinion that "*the tribals on their own never catch STI, it is only when the outsiders such as "Thekedar" visit their areas, they leave behind such problems*". In Andhra

[60] Basu, S K (1993): Health Status of Tribal Women in India, NIHFW: 4
http://www.hsph.harvard.edu/grhf-asia/forums/Tribals/Tribals/M002.HTM
[61] NACO (2001): Behavioral Surveillanve Survey Among General Population: 60-61
[62] Bhasin, V. (2004), Sexual illnesses and under utilization of Biomedicine Among Tribal Women of Rajasthan: Anthropologist, 6 (1): 1-12

Pradesh, discussions with the District Nodal Officer and the PD confirmed that the tribal girls participating in *Dimsa Dance* are made easy prey to commercial sex by the tourists with the help of local brokers/tout. According to an out reach worker associated with NATURE, a local NGO, the girls are highly vulnerable to STIs because of the tourists.

Other causes related to acute poverty in tribals areas which result in outsiders like brokers, contractors taking advantage of the system by paying measly sum as bride price and having cheap fun (already discussed in earlier section), misutilisation of the system - 'dormitories' as brothels, and financial burden pushing tribal women into commercial sex[63],[64].

3.4 AWARENESS AND ATTITUDE TOWARDS HIV/AIDS

3.4.1 Awareness of HIV/AIDS, its Mode of Transmission and Prevention

The findings of "National BSS among General Population 2001", covering both urban and rural populations, indicated that three out of every four is aware that HIV/AIDS is transmitted through sexual contact. Around 78 percent males and 65 percent females were aware that HIV/AIDS could be transmitted through needle sharing. Low awareness levels were reported among rural women in the states of Bihar, Gujarat, UP, MP and West Bengal compared to rest of the states. The potential of mother-to-child transmission was less known to the respondents across the country. Around 54 percent respondents were aware that HIV/AIDS could be transmitted through breastfeeding.[65] Other studies conducted have also reflected that knowledge and awareness about HIV/AIDS was very low among tribal communities and rural populations compared to the national figures due to isolation, low literacy rates, and minimal access to information.[66,67]

The caste analysis of awareness of HIV/AIDS in NFHS-2 revealed that only 17 percent of the ST women had heard about HIV/AIDS as compared to 32 percent of SC women, 42 percent of women belonging to OBC and 48 percent of women belonging to other castes. Further the data on source of awareness of tribal women reveals that TV, radio and friends/relatives were commonest sources. A small but comparatively higher proportion of ST women (7.5%) than women belonging to other castes also mentioned health worker as the source, reaffirming that tribal women do access services from health workers (NFHS-2, 1998-99) A study on "The assessment of vulnerability of rural populations to HIV/AIDS, 2005" reported that knowledge of HIV/AIDS among tribal people was very low compared to rural areas. Only 22 percent of the study participants (rural and tribal) had heard of HIV/AIDS, of which less than 20 percent were aware of the modes of transmission. On the other hand, in rural areas, most of the respondents had heard about the disease but complete knowledge on transmission and prevention was too low. Major sources of knowledge regarding HIV/AIDS among rural populations was reported to be radio and television, along with posters, banners, skits, one to one talk by health personnel-ANM, doctors also help in disseminating messages, exposure to urban situations/ conditions. Education was found to be a

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[63] Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Priliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal, Chapter 5: 1-9

[64] World Vision (1997) An Exploratory Study of Sexual Networking Patterns of Tribals, Navapur , Maharashtra: 13-14

[65] NACO (2001): Behavioral Surveillanve Survey Among General Population: 29

[66] DoH&FW (M) Govt. of Rajasthan (2003) :District Strategic Plan, Udaipur : 6
http://www.youandaids.org/Charca/Resources/DSP%20Udaipur.pdf

[67] World Vision (1997) An Exploratory Study of Sexual Networking Patterns of Tribals, Navapur , Maharashtra: 14

major determinant in knowledge gap through commonly used IEC. It was reported that awareness programmes on HIV/AIDS are very occasional and sporadic, with limited reach.[68]

During our primary social assessment also, discussions with tribal people indicated that the awareness on HIV/AIDS among them was low and even lesser among female members as compared to the males. The study also gives an impression that awareness about HIV/AIDS among tribals was better in Manipur and Andhra Pradesh as compared to the other states. It appeared that those with some level of education had a higher level of awareness compared to those who were illiterate with very limited level of exposure to mass media. The younger population groups apparently were more aware of HIV/AIDS than the older population, perhaps because this issue has been covered in the schools curriculum in the recent past. The source of awareness for those who knew about HIV/AIDS was - printed media that is pamphlets, hoarding and message written on the walls. *Nukkar natak*, puppet show, video films and in a few cases television were the primary sources of information. Those who were aware of HIV/AIDS reported unsafe sexual practices; multiple sex partners, blood transfusion and or use of contaminated syringes as the causes of HIV/AIDS. They mentioned that those who had STI were more susceptible to HIV than the others. They knew that HIV couldn't be transmitted through mosquito bite, sharing food, sharing towel or shaking hands and eating together. Mother-to-child transmission of HIV as a transmission mode and use condom as preventive method was rarely known among them.

In the Gariaband and Churra blocks of Chattisgarh, the female tribal members believed that HIV/AIDS could get cured. The male as well as the female tribal members of these blocks had a very positive attitude towards the people with HIV/AIDS though they had not come across any person with HIV/AIDS. They mentioned, "*If we happened to meet people with HIV/AIDS we will not alienate them"*. Some of the female tribal respondents also mentioned, *"we will help them by giving or cooking food or giving money to them'.* In these blocks some wall writings on HIV /AIDS were also observed, which served as source of awareness to the community. However in the other villages of Chhattisgarh, the male and female respondents had not even heard of HIV/AIDS indicating that no one till now had educated them about AIDS.

In Andhra Pradesh, the distance of these villages from the mandal headquaters determined the awareness level regarding HIV/AIDS. Also in the villages adopted by NGO, the awareness level of the tribal communities was better than those without NGO presence. As compared to the other study states the awareness levels among male and female tribal people was high in Andhra Pradesh with regard to causes, prevention and treatment. This was mostly true of villages with NGO presence and those close to the mandal headquarters. They believed that HIV/AIDS is preventable and even curable. This is reflected from the quote given below:

"It can be definitely prevented with the usage of condoms. Sterilized syringes should be used or new syringes should be used. At the time of blood transfusion the blood should also be tested. If the HIV infected mother takes medicines costing Rs. 2000/- per day till the time of birth of the child the chances of AIDS being transmitted to the child are reduced. It is only blood and sexual activities by which this disease is transmitted". (Unmarried male member of Kondiba village)

[68] MAMTA Report (2005), The Assessment of vulnerability of rural populations to HIV/AIDS: 24-25

"HIV/AIDS is a disease, caused when you have sex with many women. In schools we are educated by teachers to use condoms. We can control HIV/AIDS by using condoms. Also we should not have sex before marriage and after marriage only couples should have sex". (Unmarried male of Kujalli village)

"I am aware of HIV/AIDS as once the NATURE organization had conducted a programme in our village and I learnt about HIV/AIDS the first time through that programme. They had informed that this disease is transmitted through sexual activities, injections, syringes and blades at the barber's shop and blood transfusion". (Married male of Kondiba village)

"Doctors come to our school and tell us about it. It is said that people indulging in wrong acts get this disease". (Unmarried Female member of C Colony)

In Manipur, due to the intensive efforts of MSACS, Churachandpur district officials and NGOs, awareness about HIV/AIDS was better as compared to any other states. A lot of inputs has gone to Manipur in general and Churachandpur in particular Also, knowledge of its transmission modes and availability of diagnostic, treatment, care and support facilities around them was soaring. Among the high-risk group, the awareness level was extremely good. They also knew the difference between HIV and AIDS, were well aware of the diagnostic, treatment, care and support facilities run by government as well as NGOs. The names of the NGOs mentioned were SHALOM, LRRC, RIMS, etc.

3.4.2 Misconceptions about HIV/AIDS

The misconceptions reported by tribal communities were in line with the misconceptions of the general populations, reflected through review of literature. General population had misconceptions on the mode of transmission. These included misconceptions that it can be spread through mosquito bite and sharing of meals with an infected person. A study amongst tribal people found that out of 22% of people who had knowledge about HIV/AIDS, 1-7 percent believed "sinners" would get AIDS, AIDS and STDs can be prevented by sterilization of women, AIDS is acquired by looking at an infected person who has AIDS, AIDS is acquired by talking to person who has AIDS, and there is a cure for HIV/AIDS[69]

According to a study on "The assessment of vulnerability of rural populations to HIV/AIDS", in rural areas, several myths and misconceptions were associated with HIV/AIDS transmission. Most common among them was that only men who have illicit sexual relationships would get HIV/AIDS. Other myths were related to urban population; only people living in urban areas can get the infection. Some even believed that it is a traditional disease of commercial sex workers while others said 'young people will get this disease more quickly'. Youth are especially considered to be at high risk of getting infected due to their risk taking attitude which exposes them to more vulnerability than any other section of the population[70].

The prevalent misconceptions in the study states differed. In **Rajasthan,** these were,

[69] Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109

[70] MAMTA Report (2005), The Assessment of vulnerability of rural populations to HIV/AIDS: 31-32

"Sinners get AIDS"
"It is a communicable disease so the patient has to kept in a separate room" and
"AIDS is curable"

In **West Bengal,** as in case of Rajasthan some of the misconceptions reported were**;**

"Mosquito is the carrier of all infections, so we could be infected with HIV/AIDS by mosquito bite."
"One could be infected with HIV/AIDS by sharing a biscuit with the infected person".
"The HIV/AIDS infection could spread through saliva also."

*No misconceptions were reported in the tribal study areas of **Chattisgarh**.*

Even though the awareness levels of the tribal communities in **Andhra Pradesh** was better than the other study areas, still there were some misconceptions the minds of people. These were;
"I think a healthy person can get it because of the water. The mosquito that bites you and subsequently bites me can cause this disease. Some vegetables could also cause the disease"
"It is a contagious disease".

In **Manipur,** prevalence of STIs was linked to alcohol consumption.

In **Maharashtra,** the misconceptions reported were;

"Women are carriers of the infection "
"In order to prevent getting infected, men should have sex with other women"
"Shaking hands with HIV/AIDS patient can infect the other person"
*"This disease is caused **only** due to sex"*
"AIDS is spread through saliva"
"If you use the same handkerchief which used by a person having AIDS, then you can get it because the germs will be there in the handkerchief"
"You can get AIDS by kissing"
"Mosquito bite can infect you"
"If one urinates in the same place where the person having AIDS has urinated you can get it"
"Unmarried women in the age group 25-50 yrs can get the infection more easily as they have relationship with many men"

3.4.3 Attitude towards HIV Patients

Stigma attached to HIV/AIDS was either very high in some states including Manipur. It could not be ascertained in some states. It was found that, younger generations were more open towards accepting persons living with HIV/AIDS. Amongst the general public AIDS is perceived as a disease of "others" - of people living on the margins of society, whose lifestyles are considered 'perverted' and 'sinful'. In India the social reactions to people with AIDS have been overwhelmingly negative. For example, in one study 36 percent people felt it would be better if infected people killed themselves, the same percentage believed that infected people deserved their fate. Also, 34 per cent said they would not associate with people with AIDS, and one-fifth stated that AIDS was a punishment from God. Negative attitudes from health care staff have generated anxiety and fear

among many people living with HIV and AIDS. As a result, many keep their status secret, fearing still worse treatment from others.[71]

Since the tribal communities in **Rajasthan** were not clear on the modes of transmission of HIV / AIDS there was not much of stigma attached to it as revealed by both male and the female respondents. Infact they mentioned they would take extra care of such patient or treat them as any other patient who is sick. One of the respondents' said; *"AIDS ho gaya to ho gaya…"* However, when discussed with the NGOs they mentioned that in the urban areas community discards the people suffering from HIV/AIDS and this behavior is worse in case of female HIV /AIDS patients. They said there was one HIV patient in their community whose mobility was restricted to a room and eventually he died in that room. Another study observed that in the villages AIDS is considered as a contagious disease, when it is confirmed that someone has died of AIDS or is having AIDS then they forbid her/him drinking water, consuming food and limit the interaction with other household members.(District Strategic Plan, Udaipur).

According to the information received from the VCTC at the district hospital in the study district of **West Bengal**, no major trends with regard to HIV positive persons from the tribal blocks were observed. Also awareness of this issue was low amongst the tribals in the study areas, therefore their attitude towards HIV could not be ascertained.

Tribal people of **Andhra Pradesh** believed that one can get the disease if s/he moves with the affected person. The HIV positive persons were generally not accepted by the tribal people, as revealed during group discussions with the male and the female members. Some of the verbatim from villages where NATURE has undertaken activities for HIV positive persons reflect this;

"There was a family here. The wife, the husband and their two children were infected with AIDS. Both the wife and the husband have died. The children are surviving and they have AIDS. People are afraid of meeting and moving around with them. They are always kept at a distance". (Married Females member of C Colony)

The above quotes reflect that despite having high awareness regarding HIV/ AIDS and the presence of an active NGO, the community still had negative attitude towards HIV positive persons.

In **Manipur,** although the respondents reported that eating together, sitting together, shaking hands, causes no harm, they never allowed a HIV person to enter their house or come close to them. Some of the quotes are given below;

"Community members clean the containers used by the AIDS patients separately"

During group discussions with the older tribal members in **Maharashtra**, it was revealed that HIV positive persons were outcaste and isolated. However, the younger members felt that a person suffering from HIV/AIDS deserves attention and care.

[71] AVERT (2006): HIV/AIDS in India: 1-2 (www.avert.org/aidsindia.htm)

A study on "The assessment of vulnerability of rural populations to HIV/AIDS" indicated that people living with AIDS are generally discriminated. Attitude of society towards PLHAs reinforces the need for impairing proper and well-balanced knowledge about HIV/AIDS in rural communities[72]

The above study findings can be summarized as follows in order to facilitate program planners to design interventions specific to this target community:

- Low awareness and knowledge regarding STI/HIV/AIDS except in Manipur
- Widely varying sexual practices and contact with external high risk population make them vulnerable
- Specific communication strategy designed to suit the needs and culture of the target group in local dialects would be necessary. The choice of medium for communication would also be critical. Folk media, Inter Personal Communication and messages through influencer groups could be main choices
- Non-availability and/or lack of access to health care facilities was one of the main factors discouraging health seeking. Trust in faith healers and un-qualified private practitioners and easy accessibility made them rely on these sources for seeking treatments for illnesses. Role of such providers in referral needs to be reckoned in programme design
- Gender bias towards males for health care seeking needs to be addressed
- Knowledge regarding STI and symptoms are low and misconceptions that exist exasberate this situation
- High level of stigma associated with STI and HIV/AIDS is a challenge that needs to be addressed
- Youth are emerging as a highly vulnerable group in these areas

3.4.4 Causes of Vulnerability to HIV/AIDS

It is important to understand the causes of vulnerability to HIV/AIDS among tribal people if any organization wants to tackle the very root of vulnerability. This section provides clues to the programme managers to direct their focus and strategise interventions.

Populations (with in tribals) which are more vulnerable to HIV/AIDS- Socio economic and cultural milieu

Populations that were perceived to be vulnerable to HIV/AIDS were those having multiple sex partners, young people, as they are not aware to safe sex practices, migrants, CSWs, truckers, those having extra marital and premarital sex, those who were poor, and those who did not use condoms. In Manipur it was believed IDUs and college students are vulnerable

It was believed across the study villages in **Rajasthan** that young people, those who migrate; those who have sex with commercial sex workers or have multiple sexual partners, young people living in

[72] MAMTA Report (2005), The Assessment of vulnerability of rural populations to HIV/AIDS: 46-48

hostels, drivers are more vulnerable to HIV/AIDS. It was therefore suggested by the community members that;

"For the prevention of HIV/AIDS, we need to keep in mind that we should never have sex with anyone other than our spouse."(Male married respondent, Age Group- 25-49 years)

Other stakeholders like NGOs, academicians and private practitioner substantiating this said that vulnerability of young increases because of lack of information on safe sex. Also when the tribals move out for occupations during the lean agricultural seasons they are likely to get HIV/AIDS. Dislike towards use of condoms, frequenting fairs, poverty, marriage systems, premarital sexual relationships and alcoholism also made them vulnerable to HIV/AIDS. According to academicians, in some tribes men and women are prone to Trichomoniasis and vaginitis infections. This reflects that they practice unsafe sex, which could make them vulnerable to HIV /AIDS.

Group discussions with tribal male members in **West Bengal** revealed that people, who migrate, have pre-marital and extra marital sexual relations and those who are uneducated and poor are vulnerable to HIV/AIDS. They also believed that HIV/AIDS was prevalent more in industrial areas.

In **Andhra Pradesh** it was mentioned that youth, migrants, those who visit CSWs, drink alcohol are likely to get HIV/AIDS. They also mentioned Dimsa dance troop to be vulnerable to infection from the tourists, who visit the Araku valley. Some of the quotes given below reflect this;

"Men will get AIDS more than the women and children. This is because men drink and in the drunken state go to different women (FSWs). Women will get AIDS only when transmitted by men"(Married Females member of C Colony)

"Those who migrate and visit CSWs are likely to get this disease" (Married male member of Kondiba)

Community Leader of Kujalli mentioned that

"Drivers, auto drivers and smugglers who come from other places for 3-4 days, keep tribal girls for comfort and sex. Through them the dreadful disease comes to the girl".

An academician contacted in Andhra Pradesh said,

We have noted in our ongoing study that youngsters aged less than 20 years also have contacted HIV/AIDS and they are students in Ashram school. To some extent cultural factors are also responsible. In our recent survey with regard HIV/AIDS industrial areas we found that these people (tribal) have extra marital sex during Shanty days and festivals. And it leads to many complications and makes them susceptible to sexually transmitted diseases and finally HIV/AIDS".

IDUs and college students were perceived to be the most vulnerable to HIV/AIDS. They also mentioned that there is a spurt in the commercial sex activity before Christmas to earn more money. They said,

"Before Christmas, CSWs indulge in flesh trade to earn money for the festival since most CSWs belonging to tribal community are converted Christians"

The groups that were perceived to vulnerable to HIV/AIDS in **Maharashtra** were;

- Villagers/ tribals serving in defence - In Jawhar, it was reported that villagers who served in defence could possibly be infected due to their lifestyle and risky behaviour.
- Migrating population – It was mentioned that men who go for fishing to Gujarat, often do not take their family along. During this period they adopt high-risk behaviours.
- Truckers- As mentioned by the general practitioner in Talasari, in Thane, truckers were one of the vulnerable groups for contracting HIV infection as their work requires constant travel.

Review has reflected that among Indian tribal people there is a high prevalence of behavioral risk factors, coupled with ignorance, and inadequate health infrastructure, which create a potential risk for rapid spread of HIV/AIDS as well as other related diseases.[73]

3.4.5 Sexual Practices

During the present study, with respect sexual practices, the responses given by the female tribal members varied from that of the male members. Though females were hesitant to talk about sexual relationships, male were comparatively open to talk about the same. Responses from the males revealed that they (married as well as) unmarried are involved in premarital or extra marital sex. Some of the male married men also mentioned that they had sex with commercial sex workers during the period the wife was pregnant or when they migrated. Condoms were generally not used, as these were disliked.

Females generally denied that they themselves were involved in premarital or extra marital sex, but at the same time mentioned that there were "other" females in the community who had such kind of relationships. Women generally mentioned that they had sex for the first time only after the marriage. Very few unmarried women mentioned that they were involved in premarital sex. Many also reported sex among relatives.

Academicians further substantiated that though premarital sex was not prohibited extramarital relationships were prohibited to some extent. Extra marital and premarital practices were reportedly common during festival and fairs.

The research conducted during earlier times on sexuality has indicated that among tribal people there was considerable sexual freedom. These studies described the 'village dormitories', or '*ghotul*' in which the youths of both sexes slept and had sexual relationships. The studies observed that the tribals, Muria Gond had simple and natural attitude towards sex.[74] They also felt that sexual congress was a good thing, it did you good, and it is healthy and beautiful. (Elwin, 1964). However, one of the studies, which studied the dormitory system in several tribal communities

[73] Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109

[74] Verma et. al (2004): Sexuality in the Times of AIDS, Contemporary Perspectives from Communities in India: 346-347

(*Ghotul of Muria Gonds, Gitoria of Munda, Ho and Birhors, Basaghar of Parajas, Rang Bang of Bhotias, Dhumkurias or Jonkerpa among Oraons)*, observed that though these practices are continuing there has been an influx of outsiders which has disturbed their cultural system for instance Dhumkurias have taken shape of brothels where trade of tribal women as sex workers have started. Hence, sexual assault and the after math lead to them contracting venereal diseases which make them susceptible to the HIV infections and other diseases as well.[75]
Recent studies among tribal Bhil people in western India (Gujarat and Maharashtra) have reported that premarital sexual activities are common and the parents of young boys and girls are not concerned unless sexual contacts occur among individuals of prohibited degrees of kinship relations. A study correlating the occurrence of sexual activity with girls attending schools found that school going girls reported less sexual activity (13% - coital sex) than the girls who had dropped out of the school (27% coital sex). These frequencies were much higher than those reported in non-tribal communities. Another study on sexual behaviours found rates of premarital intercourse, as reported by girls, ranging from almost none to 6, 7and 9 per cent. The sample of Bhil girls ranged in the age from 12 to 19, and the girls from the younger end of the range (12 to 14 years) reported higher rates of sexual activity than the older girls. These data support the conclusion that certain tribal groups in India have relatively lenient attitudes towards premarital sexual activity, and hence are more vulnerable to risks of STIs and HIV/AIDS infections.[76]

As regards the extramarital relationships, the review of literature indicated that extramarital relationships are widely practiced by men especially when women are pregnant or nursing or during period of travel for work. The data indicated that tribal women are particularly vulnerable for HIV/AIDS since they commence sexual activity at an early age and also get married early. There were studies, which indicated that tribal women also indulged in extra marital sex.[77,78,79]

While comparing with the general population other studies have indicated that pre marital and extra marital sex is not something new in rural areas.[80] The median age at first sex in case of general public was 21 years for males and 18 years for females in the entire country. In rural areas the median age was either less than or similar to the urban area across all states.[81] This age was much higher than the tribal population, as reported in this (15-16 years) as well as several other studies.

In addition to the sexual practices of the tribal communities, it is worth making a special reference to special ethnic and religious groups involved in sex work. This is important from the point of view that these may not get included in any of the HIV prevention programmes unless they are considered as those practicing high-risk behaviour by the respective state/district. In India there are a number of ethnic groups in which sex work has a special traditional cultural status. In these

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[75] Patnaik, S.M. (2002): Community Norms of Sexual Behaviour – A Priliminary Study of Tribes of Jharkhand, Chhatisgarh and Uttaranchal, Chapter 5: 1-9
[76] Verma et. al (2004): Sexuality in the Times of AIDS, Contemporary Perspectives from Communities in India: 347
[77] Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109
[78] Gandotra, M.M. et. al (2001), Population Research Centre, MS. Univerirty , Baroda: The Demography of tribal population in Western India;1 http://www.iussp.org/Brazil2001/s40/S48_P08_Gandotra.pdf
[79] World Vision (1997) An Exploratory Study of Sexual Networking Patterns of Tribals, Navapur , Maharashtra: 11-12
[80] MAMTA Report (2005), The Assessment of vulnerability of rural populations to HIV/AIDS: 54
[81] NACO (2001): Behavioral Surveillanve Survey Among General Population: 53

groups some young girls are designated to take on the permanent status of 'unmarried' and to engage in forms of entertainment including the provision of sexual services. The Nat ethnic groups in Rajasthan, and several groups in Madhya Pradesh, including the Banchhara, Bedia and Sansia people, are among those mentioned in recent studies.[82] The Nat ethnic group was traditionally engaged in entertaining people through acrobatics *(Kalabaazi*), rope dance, traditional plays (*kartab*), *nautanki, muzra* etc serving the *Rajput* rulers and landlords of Rajasthan[83,84] . In earlier times Nat women often had sexual relations with the *Rajput* rulers and landlords. As a consequence of the loss of traditional modes of income, Nat women have become progressively more involved in sex work. In recent times many Nat groups have taken up residence near the main highways, where their women find clients among truckers. Also increasing numbers of Nat women migrate to urban areas, especially Mumbai. Somewhat similar cultural and economic developments are found among the Banchhara and Bedia people of Madhya Pradesh.[85]

The *devdasi* system of religious dedication to sex work is in many ways similar to the ethnic, group-based sex work. Though the institution of *devdasi* is now prohibited by law, and various government actions have been taken to discourage the practice, still young girls are dedicated to the *devdas*i role, especially among certain economically marginal, Scheduled Caste Groups in Karnataka. Considerable numbers of them end up in the brothels of Mumbai, Pune and other urban areas.[86]

The findings of a study on "Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS" revealed that in today's modern world, it is difficult to imagine societies that are still socially and culturally isolated from the rest of civilization; however, they do exist. The tribal societies throughout India have remained socially and culturally alienated from mainstream Indian society until developmental and conservation activities in tribal areas forced interactions between them. Some of the tribal communities did not have a structured marital system; instead members practiced a form of serial monogamy in which they change partners and remarry every four to five years. Regarding sexual practices, 35% of the respondents reported either premarital affairs or extramarital affairs. However such practices were more common in men compared to women. Furthermore, 20% of the male participants reported having had sex with a female sex worker (FSW) during the period the wife had had a child.

3.4.6 Involvement of tribal people with high-risk groups and other vulnerable groups

The primary information collected through this study as well as review of the available literature has provided enough evidences that the tribal people do come in contact with several high-risk and other vulnerable populations. This has been referred to in the context of socio-economic and cultural profile, causes of vulnerability to STIs/HIV/AIDS, sexual practices etc. It is quite evident that while tribal women comes in contact with Truckers (HRG), contractors, tourists and defence personnel (outsiders and other vulnerable groups), men come in contact with FSWs during migration (HRG). A study done by FPP and ASCI among FSWs and MSMs showed that 11

[82] Swarankar (2001), M.P. Human Rights Commission, 2001
[83] Swarankar (2001), M.P. Human Rights Commission, 2001
[84] ORG-MARG Report (1995) : Migratory Populations of Western Rajasthan: 1-8
[85] Swarankar (2001), M.P. Human Rights Commission, 2001
[86] Verma et. al (2004): Sexuality in the Times of AIDS, Contemporary Perspectives from Communities in India: 331

percent of CSWs and 5 percent of MSMs belonged to tribal communities. This was the finding randomly in 40 sites from Telangana and Rayalseema in Andhra Pradesh. Infact most of the tribal CSWs were mobile sex workers [87]

In Manipur, the single largest mode of HIV infection is IDU. In Manipur, there are approximately 20000-30000 opium users of whom about 15000 are estimated to be using drugs via injection[88]. The HIV seropositivity rate among IDU was 4 percent in 1991, which increased considerably to 73 percent in 1993[89]. Similarly, in Manipur, the first seropositive IDU was identified in October 1989 and within 6 months prevalence in this group increased to 56 percent. Once the HIV is present within the population of IDU, it can be a source for other heterosexual and prenatal transmission. One study in Manipur, an area that experienced an explosive spread of HIV among injecting drug users, has found that 50.7 percent of injectors have reported to have sexual experiences within the last 5 years. As the HIV epidemic matures, transmission from IDU to their wives and sex partners becomes the important route of infection among females and children. In addition, condom use was found extremely low, with only 3-5 percent of injectors reporting even occasional use of them another study in India found that over 30 percent of married male and female injecting drug users had extramarital sex, and less than 2 percent of them used condoms (HIV/AIDS epidemic in Manipur 2005). Data on rates of condom use among IDUs and non-injecting drug users indicate that rates may be lower among injectors. One study in Delhi, India revealed that condom use among IDUs was lower than among non-injecting drug users[90] .

All the nine districts of Manipur share a varying degree of HIV prevalence. The highest is found in Imphal district with 64.6 percent as district percentage.[91] Though drug addiction is not considered to be as high in other areas in India, but systematic surveillance begun recently indicates that addiction is much more frequent than realized. In many cities pockets of drug users have been found, but HIV-seropositive IDUs are still almost totally restricted to the north-eastern region.[92]

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[87] International HIV/AIDS Alliance, ASCI and INSP Report (2004): Key Indicators for FPP, Frontier Prevention Project Baseline study in Andhra Pradesh : 11, 46

[88] Manipur Online (2005) , HIV/AIDS Epidemic In Manipur : 2
http://www.manipuronline.com/Potpourri/November2005/hivepidemic11_1.htm

[89] Naik et. Al (2005) Rural Indian tribal communities: an emerging high-risk group for HIV/AIDS in : 3
http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=554109

[90] Kumar, et al. (1996) , "Prevalence of HIV related high risk behavior among drug abusers in a re-settlement colony in Delhi. Abstract no. Tu.C.2511. " *XI International Conference on AIDS*. Vancouver, Canada.

[91] HIV/AIDS Epidemic in Manipur, Manipur Online, Dealing with Issues, Nov 11, 2005

[92] Riehman Kara SACS (1996) Injecting Drug Use and AIDS in Developing Countries: Determinants and Issues for Policy Consideration, Background paper for the Policy Research Report *Confronting AIDS*World Bank, Policy Research Department , Levels of HIV Infection Among Injecting Drug Users, (http://www.worldbank.org/aids-econ/confront/backgrnd/riehman/indexp2.htm)

One of the study also observed Tattooing, a common practice among many tribes such as *Gonds, Bhils, Birhors* etc, as a potential contact point which definitely can increase the vulnerability of these communities to HIV/AIDS.

Many of the respondents were of the opinion that IDUs sell sex or become CSWs. Hence, drug addiction was one major cause. According to STI specialist, alcoholism was responsible for STIs as it loosened up their inhibitions. He further stated that Kuki and Paiti tribes have liberal attitude towards sex. Therefore, they could also be more vulnerable to STIs. In the FGDs and IDIs, it has also emerged that though the community did not approve of pre – marital sex, some young boys and girls indulged in pre – marital sex. To conclude, IDUs, CSWs, sexual partners of CSWs, Kuki and Paiti tribes and youth are more vulnerable owing to their behavioural practices.

3.5 AWARENESS OF PDTC SERVICES FOR HIV/AIDS

Awareness on PTDC services was low across all the study areas. In **Rajasthan** according to the Vadag Vikas Sansthan (NGO) and the other community members, the available methods for communication on HIV /AIDS were printed material, slogans on walls, street plays, puppet shows. In **West Bengal** the community members generally reported that they were not aware of any HIV/AIDS awareness campaigns. In AP people in community had come to know about HIV/AIDS through, interpersonal communication, TV, newspaper and radio. Few had also noticed wall posters. The school going youths had come to know about AIDS from their teachers. In Manipur respondents were well aware that the district hospital provides HIV testing and diagnosing facility. Awareness levels were higher among HRGs as revealed by the NGOs. Hospital run by SHALOM at Churachandpur was mentioned by almost all respondent categories to be the place for treatment.

In case of general population, only 7.4 percent of all respondents did not have exposure to any of the three forms of mass media. This varied from 1.1 percent in Kerala to 14.7 percent in Bihar. In case of general population a relatively low proportion of sample respondents had actually received some communication on HIV/AIDS/STDs during the last one-year. This essentially indicates that word-of-mouth communication has not been a prioritized means of communication for spreading awareness on HIV/AIDS/STDs. It was seen that the South Indian states (except Andhra Pradesh) reported very little inter-personal communication on HIV/AIDS/STDs. However, because respondents from these states had a high level of literacy among them and their exposure through the electronic and print media being high, these states scored consistently higher on awareness indicators. (National BSS General Population)

Studying the impact of a two- year electronic communication campaigns run by BBCWST in Uttar Pradesh, Rajasthan and Delhi on HIV/AIS showed that it does help increasing awareness of people about PDTC services. This is especially true if interesting formats for the communication are used such as the ongoing serial “Jasoos Vijay”.

3.5.1 Preferred Method of Communication

The community leaders, members, NGO representatives and academicians were very forthcoming in providing suggestions to minimize the spread of HIV/AIDS and reduce vulnerability. Their suggestions were strongly geared towards initiating communication activities. In **Rajasthan**,

communication campaign in local language through various local media like group meetings, bhajans and local festivals and involvement of local resources such as community leaders themselves, school teachers, NGOs SHGs was perceived to reduce HIV/AIDS spread.

In **West Bengal** the community leaders suggested focusing on the use of condoms. The community leader also suggested that female staff of government agencies and NGOs would be more effective for campaigns among tribal women. Also village clubs should also be involved in efforts to minimize the spread of HIV/AIDS. The suggestions made by NGOs and private practitioners included use of mass campaigning to generate awareness and use of condom through use of CDs, folk programs, street play, folk songs, folk festivals like *Chhau* dance, *Santhal* dance, group counseling through SHGs. They also felt that apart form the core issues related to HIV/AIDS, the campaigns should focus on hygiene issue (including menstrual hygiene) as most of the tribal communities live in extremely unhygienic conditions and setting up small scale industries in tribal areas to prevent migration. In **Andhra Pradesh** more emphasis was **laid on s**afe sex and imparting messages through meetings, cultural programmes and dramas, like 'borakatha', in which a person will make action and the other, will give explanation. Use of TV, VCR as well as alternate mediums to TV such as CDs and VCRs and help from youths who received HIV/AIDS information in the schools for peer education (with reference to the effectiveness of the strategies employed by a project initiated by NATURE) was also suggested. In **Maharashtra** the need of the day was that people talk freely and openly about sex, which remained the main concern. IEC programmes were conducted in schools, but they were perceived to be not reaching the right audience. Since there are a number of languages spoken in these areas, it was suggested that messages should be in the native language. Since television and radio were not available in all villages, dramas, role plays and street plays were considered to be more effective. In villages where the proportion of illiterate population was higher, suggestion was that the messages could be imparted through pictures/ written material. Local doctors could be involved in reaching grassroots population.

Since there is very low access to electronic media like radio (35%) and TV (12.8%), and print media (3.9%) the findings of a study strongly suggested use of interpersonal communication only (72.8%). It was suggested that traditional media could be an effective medium to deliver the health care messages to the tribal people. This can be achieved by establishing as well as strengthening of the existing Mahila Mandals, developing village youth forum along with a few educated youths and exploring the existing local folk artists. The media such as radio and television may supplement the activities of health functionaries and the local folk artists to make the communication more effective in the study area. (T. Mathiyazhagan). However, since there were reports of the use of alternate mediums such as CDs and VCRs, and liking of tribals towards watching TV (irrespective of the access), innovative approaches such as use of electronic as well as IPC for entertainment education could be tried to raise awareness among tribals. In recent years, the entertainment-education strategy had been applied to address a variety of social problems including unsupported population growth, gender inequality, environmental pollution and HIV/ AIDS prevention and control.[93]

[93] Singhal, A., and Rogers, E. M. (1999). Entertainment-education: A communication strategy for social change. Hillsdale, NJ: Lawrence Earlbaum Associates.
http://www.amazon.com/gp/product/0805833501/qid=1147170444/sr=1-1/ref=sr_1_1/102-0931683-8846552?s=books&v=glance&n=283155

3.5.2 Awareness and Availability of Diagnostic and Testing Facilities and Preference for such Facilities

Except for Manipur, across all the states the awareness about diagnostic and testing facilities was low. Among those who have heard about HIV/AIDS very few were aware of the availability of the diagnosis facilities. According to them the diagnosis facilities was available only in the big public and private hospitals. In AP, some of the community members mentioned availability of VCTC at Araku valley - CHC for tribal mandals. The youths were also aware of HIV diagnostic and testing facility available at S.Kota and Visakapatnam. Since awareness about these facilities across all the states was low, preferences for these facilities did not emerge from the group discussions.

3.5.3 Awareness and Availability of Treatment and Care Facilities (T& C)

As in case of diagnostic and testing facilities, the awareness of the community members about treatment and care facilities was also minimal. The awareness was high in Manipur it being ahead of other states in these initiatives.

Despite limited knowledge on awareness of diagnostic and treatment facilities for HIV/AIDS, some of the reasons mentioned for under utilization of these facilities across all the study were;

- *"People hesitate to visit nearby facilities, as it is believed that only sinners or those who visit CSW get it. Also because it is perceived to highly infectious/ contagious"*
- *"Not many people are aware of such facilities"*
- *"Poor accessibility and transportation facilities"*
- *"Doctors or other medical staffs themselves have a very negative attitude toward such patients"*
- *"Diagnosis and treatment is expensive"*

Review of literature indicated that very few people in rural areas were aware about the free treatment facilities for HIV/associated diseases (assessment of vulnerability of rural populations). With regard to doctor's and other medical personnel attitude to people seeking HIV/AIDS testing, care and support, a study conducted among health workers in 6 states showed that awareness of health workers in regard to signs and symptoms of HIV/AIDS was inadequate in some states. Health workers were not equipped for giving proper advice to suspected cases of HIV/AIDS. Inadequacy of IEC material and condom supplies and training facilities; lack of clarity of role and roles and responsibilities of different health functionaries etc has a bearing on their attitude to people seeking HIV/AIDS testing, care and support.[94]

3.6 PRESENCE OF NGOs/CBOs/SOCIAL INSTITUTIONS

Rajasthan: There were Self Help Groups in all the sampled villages formed with the help of NGO - PEDO MADA, NGO - Vagad Vikas and Anganwadi workers. These SHG's were found to be very influential. These could be used for awareness campaign among HIV/AIDS among women.

[94] NACO (2005) Rapid Survey of Health Workers: Awareness and Attitude to People Seeking HIV/AIDS Testing, Care & Support : 39-40

West Bengal: The NGOs working here were – Kalyan (working in livelihoods for the Tribal people), Fight for Purulia (working for Thalsemia in Purulia) and Paschimbanga Kheria Sabar Kalyan Samity (working upliftment of Sabar tribe).Fight for Purulia work for about 125 Thalsemia patients in Purulia.

Andhra Pradesh: In Visakhapatnam district there are five NGOs working for the programme designed for high-risk groups. NATURE was one among those NGOs and was working in the tribal mandals. It has been given the task of implementing TI for migrant and slum population by APSACS. NATURE is one of the reputed NGOs working in the Anathagiri and Araku tribal mandals of sample district. It creates awareness of HIV/AIDS issues. There are also few other NGOs in the tribal mandals working effectively for the development of tribal people. The other NGOs working are CARE, ASSAAV and ORRC. They implement health programmes in these tribal communities.

Manipur: Lifeline, Maruploi Foundation, SASO, MNP+, SHALOM were some of the NGOs, which provided free medical treatment, condom promotion, care and support, awareness programs. Though there were NGOs in some of the study states none of them really working for the HIV positive persons, except for in Manipur and AP to some extent.

Implications of the basic information findings

- The tribal people is at risk in terms of HIV and hence it is essential that interventions are designed to specifically to meet the requirements of the tribal people

- Communication strategies and media selection needs to be done in accordance with the findings of the media habits as outlined in the study

- The instances of high level of pre-marital and extra-marital sex also make them vulnerable and this aspect needs to be reckoned while designing interventions.

- The communication needs to address in the first stage increasing knowledge and awareness among the tribal people regarding the STI/HIV/AIDS as well as remove the myths and misconceptions existing in order to reduce stigma

- The strategy of training and using faith healers and other private practitioners in whom the tribals have faith in to motivate the population for bringing about a better health seeking behavior

- The infrastructure of health facilities need to be improved and human resources trained and posted in this geographic area to increase access and use of these facilities

- The capacity of the NGOs also needs to be built in this region to effectively implement interventions

Chapter 4

POLICY AND LEGAL FRAME WORK

4.1 Tribal Vulnerable Population

Vulnerable communities include those groups who are underserved due to problems of geographic access, (even in better off states) and those who suffer social and economic disadvantages such as the scheduled caste and scheduled tribes. The urban poor also can be classified under this category. The tribal population constitutes 8.2% of the population of the country. The socio-economic factors along with the low levels of literacy and other specific cultural factors make the tribal people highly vulnerable to HIV/AIDS and this Chapter attempts to analyze the policy environment to scan for specific policy aspects relating to tribal people. Attempts have also been made to capture specific components in the vertical programmes that are centrally funded that relate to tribal population in order that convergence can be used as a strategy to intervene with these populations.

4.2 Policy Environment

The following policies have been examined and analyzed for their implications on the Prevention-Diagnosis-Treatment and Care (PDTC) for the tribal people:

- National HIV/AIDS Prevention and Control Policy
- National Health Policy 2002
- National Population Policy 2002
- National Policy on Tribals 2004
- National Rural Health Mission-Vision Document
- National HIV/AIDS Bill
- Manipur State Level Policy on HIV/AIDS
- The National RCH and RNTCP Programme Documents
- India is a signatory to the Declaration of the Paris AIDS Summit in 1994 that provides for greater involvement of HIV-positive people and the UNGASS Declaration of Commitment on HIV/AIDS in 2001
- *The National Blood Policy* was announced in 2003. The policy was followed by an action plan for blood safety.
- *The National Youth Policy (2003)* which laid emphasis on health of adolescents and the youth
- The **Parliamentary Forum** on HIV/AIDS was launched on 11th May 2002, followed by a declaration in its first National Convention in 2003. Many states have also launched Legislators' Forum to strengthen the state level response.
- During 2005, the Govt. of India launched a **National Rural Health Mission** and the RCH phase-II envisaging active participation of PRIs and civil society groups and a convergence of HIV/AIDS and RCH

- Culminating this process was the decision made by the Prime Minister to head the **National Council on AIDS in 2005**.

These developments provided a supportive policy context for HIV/AIDS prevention and control activities. The next phase of the AIDS Control Programme will derive support from these policy measures and aim to fulfill the expectation generated by the commitments given by the Government of India to Indian citizens and the international community.

4.3 Analysis of Policies and Programmes

4.3.1 National HIV/AIDS Control Policy

This policy has reinforced the commitment of the Government to effectively prevent the transmission as well as provide treatment care and support to those who are already infected. National AIDS Prevention and Control Policy has to a large extent looked at the coverage of social and economic dimensions of the epidemic. The following are the salient features:

- Recognizes that HIV is particularly aggravated by situations of injustice and poverty
- It is recognized as a multi-sectoral problem and not confined only to the health sector
- NGOs and private sector have an equally critical role to play in effective prevention and provision of care and support
- It has placed emphasis on locally relevant interventions and execution through experienced community based organizations especially for the poor and marginalized sections which are vulnerable to HIV.
- The following critical issues have been recognized for bringing in a paradigm shift in HIV/AIDS response:
    - To consider HIV/AIDS as a developmental issue which impinges on various economic and social sectors of governmental and non-governmental purview
    - Necessity of a multi-sector response and workplace interventions
    - Increased ownership at the state level for bringing about an effective response
- To use advocacy and social mobilization to bring about a better understanding among the cross section of the society (legislators, political, social and religious leaders, media, leaders of trade and industry and medical fraternity) to fill the information gaps and reduce stigma and discrimination
- Provides for greater involvement of NGOs and encourage them to network and coordinate their programmes in order to reduce duplication of efforts and resources
- NGOs are considered key players because of their proximity to vulnerable communities and due to their understanding of the behavior and attitudes of this group
- Prevention of STI/RTI and STI/RTI diagnosis and treatment has been considered as an essential strategy
- Promotion of correct and consistent use of condoms (in all risky sexual acts) as part of the balanced Abstinence, Be faithful and use Condoms (ABC) approach

The policy deals with HIV testing as follows:

i. No individual should be made to undergo a mandatory testing for HIV.
ii. No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment.
iii. Adequate voluntary testing facilities with pre-test and post-test counseling should be made available throughout the country in a phased manner. There should be at least one HIV testing centre in each district in the country with proper counseling facilities.
iv. In case a person likes to get the HIV status verified through testing, all necessary facilities should be given to that person and results should be kept strictly confidential. Such results should be given out to the person and with his consent to the members of his family. Disclosure of the HIV status to the spouse or sexual partner of the person should invariably be done by the attending physician with proper counseling. However, the person should also be encouraged to share this information with the family for getting proper home-based care and emotional support from the family members.

Care and support for People Living With HIV/AIDS (PLWHAs)

The Government stresses the need of equal rights to education and employment, maintaining confidentiality about the HIV status, his or her position at the workplace, marital relationship and other fundamental rights especially women's (HIV+ve) choice in making decisions regarding pregnancy and childbirth.

Encouragement and active support to the formation of self-help groups among the HIV-infected persons for group counseling, home care and support of their members and their families is envisaged by the Government. It is also expected that the health service sector displays necessary concern for the welfare of the community of PLWHAs and ensure proper medical care and attention.

HIV and Injecting Drug Use

Government considers the problem of injecting drug use through needles as a serious issue and is committed to adopt appropriate strategies for preventing the risk of transmission through injecting drug use. Towards the same, the Government plans to encourage NGOs working in the drug de-addiction programmes to take up harm minimization as a part of the HIV/AIDS control strategy in areas, which have a large number of drug addicts.

HIV/AIDS and human rights

Government recognizes that without the protection of human rights of people, who are vulnerable and afflicted with HIV/AIDS, the response to HIV/AIDS epidemic will remain incomplete. The National Conference on Human Rights and HIV/AIDS also recognized the need to understand the exact manner in which factors of gender, caste, region, class, and sexual orientation influence the

impact of Human Rights issues for different sections of the society. Along with the social and economical factors, it stressed, are the laws, which complicate the influence of these factors.[95]

Government will thus adopt the following measures to implement an effective rights based response.

- Review and reform criminal laws and correctional system to ensure consistency with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.
- Strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy, confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.
- Ensure support service to educate people affected by HIV/AIDS about their rights; provide legal services to enforce these rights and develop expertise on HIV related legal issues.
- Promote wide distribution of creative, education, training and media programmes designed to change attitudes of community towards discrimination and stigmatization associated with HIV/AIDS.
- Collaborate with and through the community to promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

Analysis of the policy in the context of Tribal People

- The policy does not have anything specific regarding vulnerable tribal people.
- The scope in the policy is wide enough to in its statement regarding vulnerable population in order that the tribal people can be included under this category
- The emphasis on locally relevant interventions through experienced community organizations has implications for working with tribal people
- The advocacy and social mobilization though does not explicitly bring about the tribal population it can be interpreted to mean that the social and religious leaders along with the village leaders need to be involved in the tribal areas
- Community involvement and empowerment of community through community dialogue is also an important aspect of tribal intervention
- The vulnerability and risk factors that have been identified in the section on basic information on tribals also suggests necessity to initiate interventions among this population

[95] National Consultation on Human Rights and HIV/AIDS: Organised by National Human Rights Commission in Partnership with NACO, Lawers Collective, UNICEF and UNAIDS, New Delhi, 24-25 Nov, 2000

4.3.2 National Health Policy 2002

The main objective of the policy is to achieve acceptable standard of good health among the general population in the country. The approach would be to enhance access to decentralized health system by strengthening the health infrastructure in the deficient areas and by upgrading the facilities in existing institutions. The policy emphasizes the requirement of equitable access to health facilities/services across the social and geographic expanse of the country. The policy recognizes the importance of increase in public health expenditure as well as increasing the capacity at the national and state levels to enhance the public health administration capability. One of the important goals that have been outlined in the policy is achieving zero new infections in HIV/AIDS by the year 2007. This provides the emphasis that the public health is placing on prevention and management of HOIV/AIDS. The key features of the policy are:

- To increase public health investment up to 2% of GDP by the year 2010 and also increase the public health expenditure to 6% of GDP. The states are also concomitantly expected to increase their expenditure and investment
- To reduce and overtime eliminate inequities and imbalances across regions, across the rural-urban divide and across the different economic classes through increasing outlay in the primary health sector
- Increase the ownership of the state in respect of all the vertical programmes and also bring about convergence of the different programmes at the field level units to realize greater synergies and eliminate wasteful duplication
- The implementation of the programme at the state levels is envisaged through autonomous bodies and the health department would be only monitoring the progress of the programme.
- Capacity building at state level to design evidence based program as well as in result orientation through better monitoring and evaluation
- Improvement of health infrastructure at the primary levels, capacity building of service delivery personnel and motivation for bringing about accountability and client orientation into the system
- To increase the pool of qualified service providers the policy recognizes the importance of inclusion of licentiates as well as the practitioners of Indian system of medicine
- Greater involvement of local self-government institutions
- The need for modifying standards of medical and nursing training as well increasing the number of medical colleges as well as reorienting the syllabus towards public health are initiatives envisaged
- The other aspects of the policy are the increase in the specialists, increasing capacity, clearer and more important role of communication and the increased role of NGOs and the private sector
- Improvement of drug procurement and logistics as well as emphasis on women's' health and health information and research

Analysis of the policy in the context of Tribal People

- The policy does not have anything specific regarding tribals but the equity objective stated in the policy provides for access across regions and social classes which can be construed as beneficial to tribal people
- The increased outlay at the primary health to create primary health infrastructure would facilitate to increase the access and use of public health system by the tribal people
- The goal of zero new infections by 2007 stresses the urgency of the government in working with all possible groups to reduce the transmission and therefore one can indirectly derive that tribal group would form a necessary part of this
- The capacity building of the medical and paramedical staff would also provide essential difference in quality of service as well as in the attitude of the service providers

4.3.3 National Population Policy 2000

The National Population Policy mainly focuses on the population reduction and the maternal and child health outcomes. However, the policy has a section relating to the necessity for providing services to the underserved population and this includes the tribal population. The service provision through mobile health services to this segment and also provides for couple protection through contraceptives and other family planning services offer scope for convergence with this programme. Further the stress on RTI management in women especially in the underserved population also offers scope for integrating with the programme.

This policy has implications for the tribal population in terms of provision of services and provides the scope for convergence.

4.3.4 National HIV BILL

The Bill provides for the following:

- Prohibition of discrimination which states that no person shall be subject to discrimination in any form by the state or any other person in relation to any sphere of public activity including employment, health care, education, and in any sphere such as accommodation, movement and holding office
- Provides for informed consent that provides right to autonomy and for testing, treatment and research
- Rights to disclosure of information and right to privacy except under exceptional circumstances allows for partner notification
- Provides for right to health and provides for access to testing, treatment and counseling
- Provides for right to safe working environment
- Social security provides for framing, formulation and implementation of health insurance and social security schemes by state governments
- Right to information and education relating to health and the protection of health from the state
- It provides for an appointment of Health ombud to discharge and exercise the powers conferred upon and the functions assigned at the district level

- It provides for the composition and functions to be performed by HIV/AIDS organizations at different levels
- It provides for suppression of identity in court
- The obligations of the state for different aspects such as pregnant women, children are also provided for

Analysis of the policy in the context of Tribal people

Though there is no mention of tribals the Bill is all inclusive and is applicable to all aspects including tribal areas

4.3.5 National Rural Health Mission

- The National Rural Health Mission (2005-12) seeks to provide effective health care to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure
- It aims to undertake architectural corrections of health systems to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country
- Provision of an Accredited female health activist and preparation of village health plans through a local team headed by Health and sanitation Committee of the Panchayat, strengthening the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards
- Convergence of all vertical programmes at the district level through a single District health society
- It aims at effective integration of health concerns with determinants of health like sanitation and hygiene, nutrition, safe drinking water through a district plan for health
- It seeks to improve access of rural people especially poor women and children to equitable, affordable accountable and effective primary health care

Analysis of the policy in the context of Tribal people

The policy provides for development of village level plans by involving the local population as well as integration and convergence of the different vertical programmes at the district level. The focus is on the 18 states that have weak outcomes and infrastructure and therefore it is expected that the concerns regarding requirements of programmes for prevention of HIV among tribals would be addressed. The service provision and ASHA at each village provides an opportunity for increased access.

4.3.6 National RCH and RNTCP Programmes

The National RCH and RNTCP programmes have drawn up a specific plan to address the tribal population and both the programmes have discussed the issues in the tribal population:

Demand side barriers to accessing services

- Poor connectivity to health services because of distance, topography, and lack of public transport
- Locational disadvantages of health facilities
- Social and cultural barriers especially for women

Structural Constraints

- Lack of flexibility and reduced responsiveness to local diversity and needs
- Scarcity of financial resources

Human resource management constraints

- Lack of appropriate HRD policies to encourage/motivate the service providers to work in remote tribal areas
- Poor work environment and dissatisfaction amongst the work force
- Under staffing of remote or even semi-remote facilities
- Weak monitoring and supervision systems

The other issues such as lack of involvement of faith healers and unqualified providers and religious leaders also are a concern that needs to be dealt with. The programmes have developed strategies and similar approaches can be adopted for HIV/AIDS as well.

4.3.7 Manipur State Policy

The state of Manipur has developed a HIV/AIDS policy for the state and this can serve as a guideline for other states and develop policies specific to their state. The policy has positive features such as:

- Recognition of the urgency and importance of the problem of HIV in the state and the recognition of the transmission modes
- The necessity for the health infrastructure to protect women and children
- Recognizes TB as a major co-infection along with HIV and hence has drawn up policy to effectively cope with this
- Outlines steps for bringing about a coordinated multi-sector response
- Recognition of Harm Reduction Approach and implementation of Rapid Intervention and Care (RICA)
- Necessity of IEC material in local dialects and languages has been recognized
- Infrastructure requirement to provide care and support to infected and affected
- The roles to be played by different agencies has been clearly spelt out
- Specific policies with respect to different aspects has been identified and stated.

The details of the policy is provided in the Annex 4.1

4.4 REVIEW OF EXISTING LEGAL POLICIES/ISSUES

Women

There are contentious issues with respect to law, matrimonial relations, and female sexuality, which are based on power structures and certain cultural sanctions regulating women in society. Cross cutting issues of class, gender, sexuality and poverty deprive women of their Human Rights. Silence around issues of sex and sexuality, comes in the way of HIV related education, making informed and responsible choices difficult. It also contributes to sex workers being seen as aberrations, deviants and dissidents, which heighten their vulnerabilities.

HIV/AIDS has also thrown up areas of conflict over rights such as informed consent, confidentiality and partner notification, which work differently for men and women. The gender dimensions in these areas need further investigation, understanding, and tackling.

Sex workers

Laws, which are intended to be protective of women, have in practice worked against their interests, especially sex workers. In addition to the laws that make women vulnerable to HIV in general, sex workers have to contend with the use, abuse and misuse of The Immoral Traffic in Women and Girls Prevention Act, 1986 (ITPA). The ITPA espouses mandatory testing, which is detrimental to public health and the National AIDS Policy. The HIV Bill 2005 has already taken care of this.

Children and Young People

The Indian Constitution mandates the State under Article 39 to ensure that "children are not abused and that childhood and youth are protected against exploitation and against moral and material abandonment". India ratified the CRC on 11th Dec. 1992. When countries ratify the convention, they agree to review their laws relating to children. This involves assessing social services, legal, health and educational systems as well as the level of funding for these services.

In the context of laws specific to issues related to HIV/AIDS, there is an absence of any specific laws to deal with the issue of child sexual abuse. Related criminal laws (Sections 376, 377 and 354 of the IPC) are inadequate and provisions relating to evidence and criminal procedures are not suited to deal with such cases. According to the provision of the Immoral Trafficking Act (prevention) 1956, presumptions are created with respect to certain offences against a child (less than 16 years) and a minor (between 16-18 years) and severe punishments are prescribed for procurement of prostitutes and prostitution in public places. These provisions need to be re-evaluated in light of experiences that show that empowerment of sex workers is effective in restricting entry of children into sex work.

People Infected and Affected

The most significant impact of HIV/AIDS has been seen in a number of cases where people living with HIV/AIDS (PLWHA) have been denied jobs or been terminated from employment because of their positive status. Apart from discrimination by the employer there is discrimination and isolation

by co-workers. Employers have in fact, considered pressure by co-workers as one of the bases for discrimination. There is a need to provide information to employees in this regard and to take positive steps to prevent such discrimination at the workplace. The HIV Bill 2005 has adequately addressed this but needs to be implemented effectively. Education of PLHA on the available legal provisions is necessary to seek legal redressal.

Sexual Minorities

Section 377 of the Indian Penal Code criminalizes "carnal intercourse against the order of nature". The punishment prescribed under this provision is imprisonment for a maximum of ten years and fine. The offence does not differentiate between consensual and non-consensual same sex behaviour. There is no legal recourse against sexual abuse and violence within same sex behaviour. A complaint under Section 377 would implicate the person offended as well. As such, the law does not recognise male rape and child sexual abuse of boys. Section 377 is the basis of harassment of sexual minorities. The police pick up people from public spaces, such as parks and public toilets. Extortion, violence, sexual harassment and other violations of basic rights occur frequently. Harassment is even more severe when the person is an effeminate male. The laws relating to Obscenity and Public Nuisance, under the Indian Penal Code and the local Police Acts are also used to harass people from sexual minorities. The law does not even recognise the existence of trans-gendered people. It is difficult for them to get ration cards, voter identity cards and passports. In such circumstances, it is not possible for them to access their rights. As long as Section 377 criminalizes same-sex behaviour there may be no legitimate intervention or development of any support structures for sexual minorities. Despite this many States have taken cognisance of some issues related to sexual minorities in their response to HIV/AIDS.

Injecting Drug Users

The NDPS Act provides for the prohibition and regulation of cultivation, collection, production, manufacture, transport, export, import inter-state and in and out of India, transhipment, possession, use, consumption, sale, purchase, warehousing, trafficking etc. of narcotic drugs and psychotropic substances which are enlisted in schedules to the Act. The Act recognises a difference between a drug dealer and a drug "addict". There is provision for an addict to be released on probation if she/he undertakes to undergo medical treatment at a hospital maintained or recognised by the government. In practice, the NDPS Act is rarely used in the manner envisaged. Drug dealers and peddlers are rarely prosecuted, while the user is often subjected to harassment, physical violence, and extortion of money and drugs. Apart from the abuse of the powers under the NDPS Act, other criminal laws are used to harass intravenous drug users from the lower economic strata. Police harassment has a serious impact on the efficacy of health and rehabilitation interventions.

MSM

A desk review of HIV/AIDS and MSM in India recommended repealing section 377 IPC, which criminalizes MSM sexual activity and introducing law reform that provide criminal legal sanction for non consensual sex, with a focus on child abuse; introduce law reforms and repeal laws to prevent abuse and harassment by the law enforcement machinery.

Tribals

The Fifth and Sixth Schedules of the Indian Constitution provide protection to tribal populations on account of their disadvantages. The Fifth Schedule designates 'Scheduled Areas' in large parts of central India in which the interests of the 'Scheduled Tribes' are to be protected. The" scheduled" or "agency" areas have more than 50 percent tribal population. The Sixth Schedule applies to the administration of the states of Assam, Meghalaya, Tripura and Mizoram in the North-east. This schedule provides for the creation of autonomous districts, and autonomous regions within districts as there are different Scheduled Tribes within the districts. The broad strategy that evolved from the constitutional mandates was the adoption of the Tribal Sub plan since the Fifth Five Year Plan of the Government of India and the Integrated Tribal Development Approach, adopted and implemented with some modifications by subsequent government programmes. Articles 46 and 47 of the Constitution of India provide a framework for tribal policy. Article 46, for example, provides the following directive: "The State shall promote with special care the educational and economic interests of the weaker sections of the people, and in particular, of the Scheduled Castes and Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation". Article 47 states that it is the duty of the State to raise the level of nutrition and the standard of living of the people, as well as to improve public health. An important objective of the National Health Policy, 2002 is the overriding importance to be given to ensuring a more equitable access to health services across the social and geographical expanse of the country and ensure that the access to, and benefits from, the public health system is ensured for tribals along with women, children and other socially disadvantaged sections of society. In response to these Constitutional provisions, the health sector has generally treated tribal areas as requiring higher health facility: population norms and are provided service accordingly.[96]

A National Commission for Scheduled Caste and Scheduled Tribes has been set to investigate, monitor and evaluate all matters relating to the Constitutional safeguards provided for the Scheduled Castes and the Scheduled Tribes (Article 338)[97] .

4.5 DISCUSSION

Manipur State level reviews showed that there is limited information on legal and structural constraints faced by HRGs in the state and there has been inadequate advocacy with decision makers and law enforcement agencies to support community-based initiatives.

Rajasthan: On policy and legal framework issues, the major takeouts of the discussion at RSACS have been the followings;

- RSACS has established one anti-discrimination cell at Jaipur. But due to lack of publicity, the cell could gain the anticipated popularity among people. RSACS has now called in partnership with State Human Right Commissioner on trial basis to improve the compliance rate. Similarly, community care centre at Jaipur also provides legal services to PLHA. Since community care centre is also known to legal care services to PLHAs are reportedly also being provided

[96] Integrated Disease Suveillance Project, Tribal Development Plan (2002): 3-4 http://mohfw.nic.in/TDP.pdf
[97] Annual report (200-01): Ministry of Trobal Affars : http://tribal.nic.in/chapter1.html

through community care centre but to a very limited scale because of lack of popularity of centre.

- Involvement of people living with HIV/AIDS did not feature anywhere in the state strategy but in NACP-III; greater involvement of people living with HIV/AIDS (GIPA) would be the central strategy in the state. GIPA will gain importance at all stages of programme from policy formulation to monitoring of programme. They will be seen as resource persons. RSACS will provide advocacy and technical support for policy changes to enable GIPA.

- RSACS strategize to build capacity of NGOs, PLHAs, service providers etc. on human rights and legal aspects to address social isolation faced by PLHAs. The state would also ensure multi-sectoral response to address and protect the legal and human rights of PLHA.

Chhattisgarh: CGSACS is under the process of establishing an anti-discrimination cell. It was reported that at present, people with HIV/AIDS are not aware their rights and there is a need to create a platform for them.

Maharashtra: HIV/AIDS, over the period of time has become a stigma amongst masses, which has affected rights and contributions of PLHAs. There is a pressing need for legislation and a provision of a legal framework, which would contribute, to making the environment conducive for existence.

As charted out in the draft Project Implementation Plan of the MSACS for NACP III, there is urgent need to review and regulate existing policies for VCT, blood testing, PPTCT with regards to children, more so in rights perspective. The existing policies related to HIV/AIDS need to be reviewed to provide a framework and mechanism for redressal of complaints of stigma and discrimination faced by women who are infected, affected and widowed and their children. According to the draft PIP, girls' age at marriage is linked positively to their vulnerability to HIV/AIDS. There is a need to strongly enforce the Child Marriage Restraint Act. Availability of inexpensive prevention options should be boosted and scientific research for women controlled prevention methods should be supported. There is a need to incorporate gender dimensions of HIV/AIDS in the proposed National Law on HIV/AIDS. In addition, there is need for a State Task Force on adolescence education, according to the draft PIP of MSACS.

West Bengal: There is no separate set of legal policies/ issues in West Bengal for HIV/AIDS. WBSACS follows the guidelines of National AIDS Control Organization as far as legal policies/issues are concerned.

However, it has been suggested under NACP III that State level legal cell may be created to link this community structure for providing support.

It has also been suggested that the state should create legal environment through advocacy for protection with regard to Section 377, 292, sexual assault (particularly for *hijras* and *laundas*), specific legal aid cell, and trafficking issues, massage parlours and *hijra* residential areas.

A review of the National AIDS Prevention and Control Policy, existing laws and the processes to amend the laws reveal that though these have been carefully drafted touching all the important issues, there is no specific mention of the specific population groups such as tribal populations and

other indigenous groups. Since the focus of the HIV/AIDS programme has been identifying high-risk and vulnerable populations, it probably has in the larger sense covered this issue. However, when it comes to implementation of the programme at the state level and below, the programmes largely narrow down on the high risk groups that been identified at the national level. The states though have attempted to identify vulnerable groups other than the high-risk and the bridge groups; these have been identified in and around the urban and semi-urban areas. Perhaps the reason has that there are very few or no NGOs working for such indigenous groups, and even if there are, there is general discomfiture of working on issues related to HIV/AIDS. It is felt that if there is a directive from the National level to the states, they will be encouraged to identify special population groups like tribals and include it in their strategic focus.

Though the NACP has already started working towards Greater Involvement of People Living with AIDS (GIPA), and all the states have got directives to initiate work on it, it does not find appropriate mention in the National AIDS Control and Prevention Policy. The working group on GIPA, Human Rights, Legal and Ethical Issues has recommended the NACP III Planning Team to include GIPA as an integrated and critical strategy in the national programme framework. It envisions that empowered involvement of people living or affected by HIV/AIDS is critical to appropriate and effective response to the epidemic in India.

Overall findings from the review

There are no specific policies that directly impinge or address the tribal issues but there is enough scope to derive from the various policies that there are areas that can be interpreted to be applicable to the Tribal Population. This has been discussed in the interpretation section of each policy. However, it is concluded that specific issues addressing the requirements of tribal population needs to be developed separately drawing from the different policies that are already in place. This exercise needs to be carried out on a priority basis.

Chapter 5

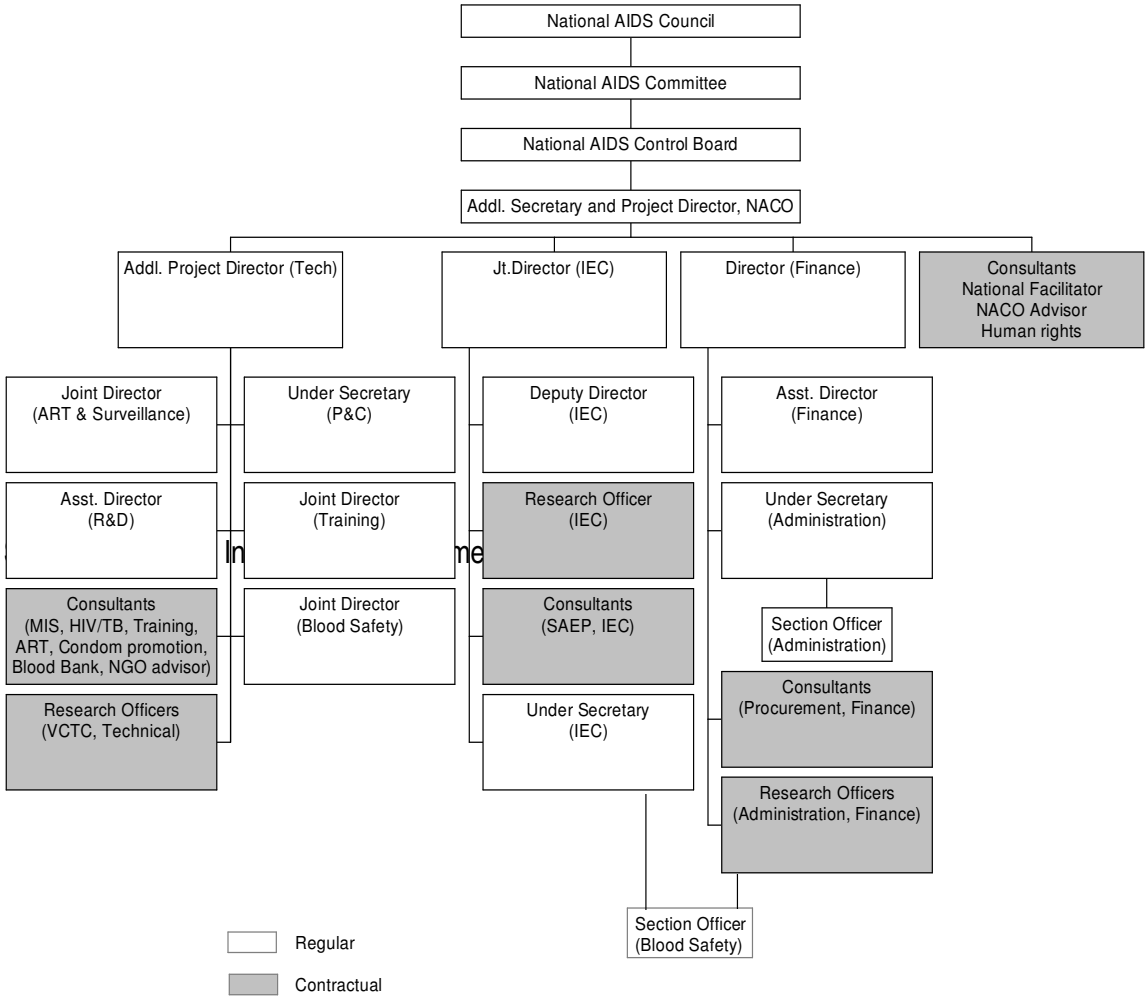
INSTITUTIONAL FRAMEWORK

This section outlines the Institutional Arrangements in the context of Social development and Tribal Issues. The chapter does not attempt to capture the Institutional framework in detail because the details are available in the Institutional Assessment report.

5.1 NATIONAL LEVEL INSTITUTIONS

The following schematic provides the Organization structure at the National level.

Organizational structure of NACO[98]



[98] Institute of Health System (IHS), Hyderabad (2005): Institutional assessment of NACP, a NACO Supported study: 7

Three entities oversee NACO; they are National Council on AIDS (NCA), National AIDS Committee (NAC) and National AIDS Control Board (NACB). NCA is more supportive than supervisory. NAC provides overall policy directives. NACB is empowered enough in financial matters.

National AIDS Control Organization (NACO), a unit in MOHFW directs and co-ordinates National AIDS Control Programme in the country. NACO is the designated agency for the control of HIV/AIDS interventions that are initiated and financed by, or through, the Government of India. In this apex role NACO is responsible for formulating strategy, reducing it to specific tactical interventions, and facilitate implementation.

Observations on national level structure

- The structure is neither a functional structure (functions such as TI, IEC, Blood safety, STI, Surveillance, Monitoring and Evaluation, Research, Finance, Social development Including gender, care and Support etc.,) nor is it a programme component oriented structure. The mixture of the two without clear designated accountability with appropriate functional grouping has made the functioning weak with diffused accountability
- The facilitation function to guide the States strategically and programmatically have also not been clearly defined
- The function of Social development, Gender and Human Rights has not been explicitly incorporated
- Too many positions of consultants without any specific accountability or deliverables defined
- Due to diffused role and job definitions the administrative and programme functions get mixed and the result is decision making is delayed especially in the context of programme/project where timely inputs and decisions are critical to accomplishing outputs

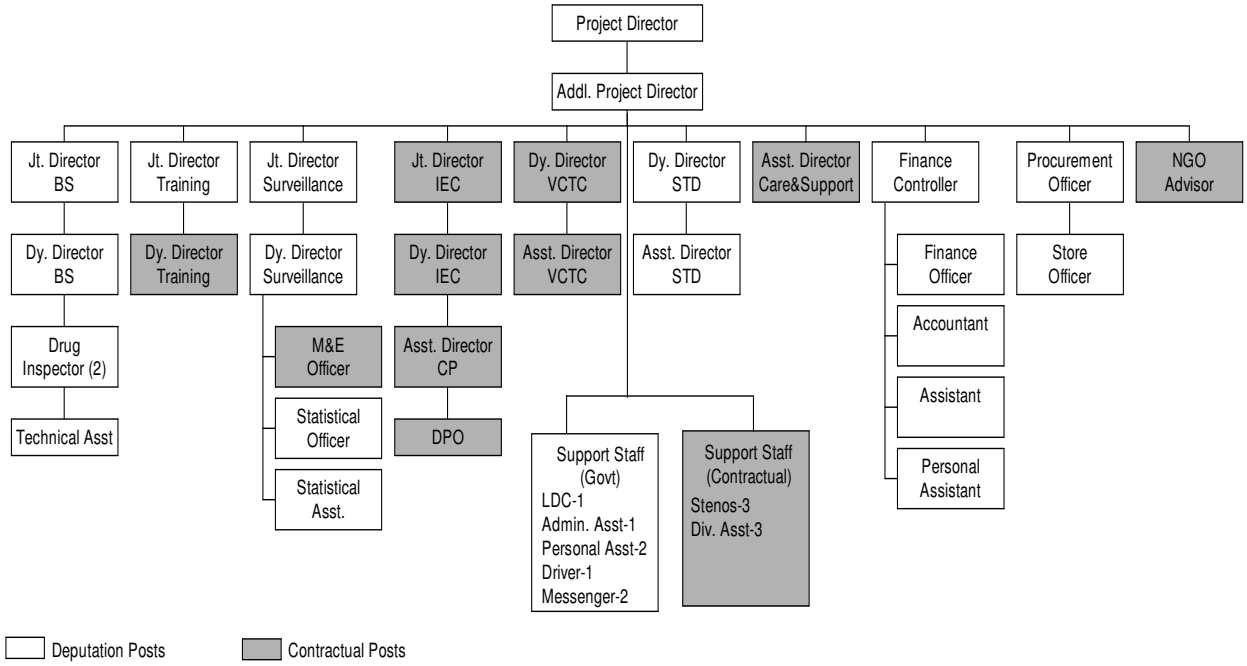
5.2 STATE LEVEL INSTITUTIONS

Organizational structure of SACS

In Phase 2, it was decided that SACS of large (>50 million population) and medium size (10-50 million) states would be headed by an officer of the IAS cadre who had the experience of serving as a District Collector. An IAS officer or any suitable person, depending on availability may head the SACS belonging to the third group. But there have been some variations on account of local compulsions and constraints. The structure is provided in the following schematic[99]:

[99] Institute of Health System (IHS),Hyderabad (2005): Institutional assessment of NACP, a NACO Supported study: 17

Fig-3: Current Organogram of SACS in larger States



Source: Modified from the Report of the CAG on the Union Government Union Government (Civil) Performance Appraisals (3 of 2004)

SACS has two supervisory bodies- **The Governing Body** and **Executive Committee.** The Governing Body has the authority to exercise and perform all the powers, acts and deeds of the Society. The annual budget and the annual action plan of SACS have to be approved by the Governing Body before it is passed. The Governing Body at its discretion may delegate its powers to any authority of the society, appoint committees, sub-committees and boards etc., and develop and adopt its own rules and regulations for recruitment and appointment of experts and administrative / technical staff and set its own compensation package for such experts / staff to be recruited from the open market and/or deputation basis.

The Executive Committee is responsible for the timely and effective implementation of 5 yearly, annual, and quarterly work plans as detailed in the project implementation plan. The Executive Committee is chaired by the Health Secretary. Its membership is more or less similar to that of the General Body. Normally it meets about 3-4 times a year.

The targeted Interventions are implemented by SACS through the NGOs working with SACS contracts and report through the NGO Advisor in the State. The other programmes are implemented through the Department of Health and Family Welfare Structure and through the other departments in the state government.

SACS does not have an implementing line organization of its own and is significantly dependent on the line organization of the State Department of Health for implementation of much of its activities. Moreover, given the inter dependent and crosscutting nature of items on the government's HIV prevention agenda, key policy objectives can not be achieved without several different governments, departments, agencies and external partners working together. Therefore, critical management issues including social management are more horizontal than vertical and require

coordination and management of a set of activities between two or more organizational units, where the units in question do not have hierarchical control over each other and where the aim is to generate outcomes that can not be achieved by units working in isolation. The structures and processes used to achieve coordination can range from informal networks to more formal mechanisms.[100]

Observations on the state level structure

- The structure is functional but the programme management orientation is missing in most SACS. The SACS are critically dependent on the type of leadership and the frequent change of the Project Directors is a cause for concern
- There is no functional position of Social Development, Gender and Human Rights within the existing SACS arrangement
- There is no separate function of Research and Monitoring and Evaluation.
- The culture within the SACS is not project oriented and there is no accountability for delivery of results and since it is only a position of deputation for most positions in SACS there is not much result orientation. The performance depends upon the leadership provided by the Project Director
- The procurement function is a weak area in most of the SACS
- The representation at the decision making bodies can be expanded to include representatives from socially weaker sections and also from the tribal development departments in order to take their needs into account
- The work load on the NGO advisor is extremely high especially in states that have a large number of interventions and it may not be physically possible to manage the interventions
- Capacity building can be a critical area for SACS personnel as the programme and project management orientation is considered weak

5.3 DISTRICT LEVEL INSTITUTIONS

Currently the NACP does not have any structure of its own below the State level. The programme is implemented in districts through the institutions of Department of Health, other state departments such as Department of Education and through partnerships with NGOs. Funds for interventions at district level are released through the District Medical & Health Officer or Head of Institution of Medical College, except that for targeted interventions through NGOs which is released through the SACS. The coordination and monitoring of the programme is entrusted to the DMHO of the district who is helped by a designated District Nodal Officer, who is generally the programme officer of other programmes such as TB, Leprosy, and Blood Banks etc. Physicians Responsible for AIDS Management (PRAMS) who are trained in the management of AIDS patients, are based in Medical Colleges and District Hospitals. The District AIDS Committees under the leadership of the District Collectors are dormant in most districts and does not gain the requisite attention from the top district administrators.

Issues at District Level

[100] Institute of Health System (IHS),Hyderabad (2005): Institutional assessment of NACP, a NACO Supported study: 13

- The lack of timely disbursal of funds due to non compliance with procedures (mostly relating to documentation) or lack of funds with SACS.
- Officers of many of the reporting units in the district did not know whom to contact in SACS either for technical or administrative support.
- The lack of support for documentation and reporting.
- Lack of a full fledged district level structure

In order to overcome the gap at the district level the following alternatives are suggested. The working group constituted by NACP III Planning Team has also suggested certain arrangements at the district level. The Tamil Nadu PIP has also suggested structures at the District Level designated as a District AIDS Unit with its own structure but the form and content is yet to be proposed.

Proposed district level structure:

In thinking about the possible structure for the district level unit, four alternatives emerge.[101] The difference in structure will be dependent on the mechanism of funding and the level of control to be exercised by SACS on the district unit. All alternatives envisage a district programme officer exclusively for HIV, who will be the nodal officer and focal point for all HIV related activities in the district. In the first three alternatives, he/she will be similar to district programme officers of other centrally sponsored programmes in that he/she will be under the administrative control of the DMHO but will also report to SACS.

Alternative 1: The arrangements will be more or less similar to existing one, with the district programme officer being an upgraded version of the DNO. Funds for district activities within the public health sector will be released through DMHO or heads of medical colleges and for other activities like TIs; funds will be directly released by SACS to partnering agencies.

Alternative 2: Envisages, an autonomous district society as in the case of current TB programme with the district programme officer having a similar role as that of district TB officer and funds released to the District AIDS Society by SACS.

Alternative 3: Foresees the district unit under the purview of the NRHM District Health Society, and funds for district activities released to the District Health Society by SACS.

Alternative 4: Is a variation of the second one, where the district programme manager will be on deputation to the District AIDS Society and will be under administrative control of SACS instead of the DMHO.

The first three options provide for greater integration and convergence with the public health system and other national programmes. The fourth option provides greater control of SACS on district level activities.

[101] Institute of Health System (IHS),Hyderabad (2005): Institutional assessment of NACP, a NACO Supported study: 28

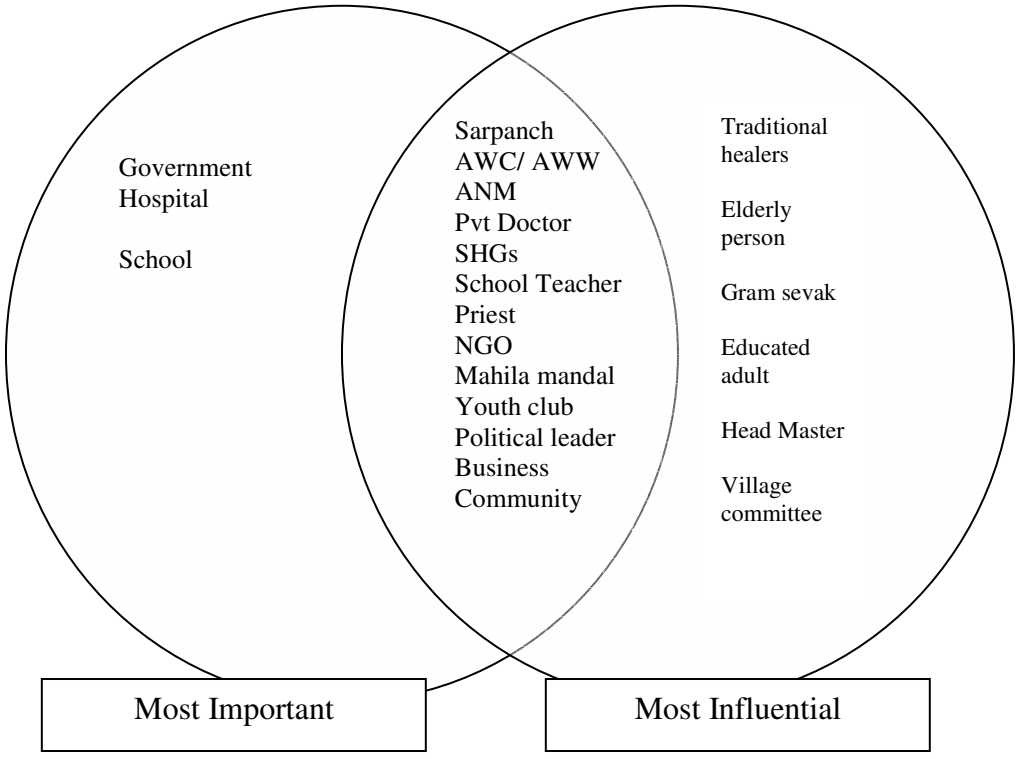
Broadly, the role of the District unit will include:

i. To be the focal point for all HIV related activities in the district
ii. Coordination with State AIDS Control Society for implementation of all components of NACP in the district
iii. To prepare District specific AIDS control action plan
iv. District and sub-district convergence of NACP with other programmes in the health sector
v. District level intersectoral collaboration and programming
vi. Monitoring and evaluation
vii. Identification of potential partners for the programme and to ensure NGO support for community mobilization and awareness

5.4 VILLAGE LEVEL INSTITUTIONS

Village level institutions were identified through Venn diagramme technique of PRA tool kit during primary social assessment with the idea of identifying potential networking persons/institutions for HIV/AIDS programme at the village level. Of the two circles given below, one represent group of institutions/ persons carrying high importance but low influence with the community. The other circle contains a set of institutions/ persons having high influence but low importance in the community. The section circles that overlap each other comprise those institutions persons which are most important as well as most influential.

Potential Networking Persons/Institutions at Village Level



Overall, Sarpanch/ Panchayat members, anganwadi worker, ANM, private medical practitioner, Self Help groups, *mahila mandal*, youth club, village priest, schoolteachers etc were reported to be the most important and most influential persons/institutions. Government hospital and school was perceived to be the most important for the village community but influence of these two institutions was perceived as low. On the other hand, traditional healer, elderly person, gram sevak, educated adult and school head master were reported to be the most influential as their work is appreciated but may not have say in taking important decisions about the community developmental activities. Hence, at the village level it is proposed that a village volunteer (such as ASHA in the case of NRHM) be available to make the organizations and other entities at the village level to carry out advocacy as well as prevention within the villages. The stakeholder analysis that has been carried out as part of the primary assessment in the select districts can provide clear roles for advocacy and also define the roles that can be played by each of the stakeholders. This could also provide strategic guidelines for initiating programmes at the village level especially along the P-D-T-C lines.

5.5 NON-GOVERNMENT ORGANIZATIONS

There are numerous NGOs working on HIV/AIDS at the local, state and national level. Funding for NGOs comes from a variety of sources- the state government, international donors, and local contribution. The type of projects undertaken by NGOs working in the study states included targeted interventions for high risk groups (CSW, IDU, MSM) and bridge groups (truckers, migrants) and vulnerable groups (slum population, street children, prison inmates, eunuchs, transgender), slum interventions, School AIDS Education Programme (students), Care and support for PLHAs (community care centre, drop in centre, PLHA networks), STI mobile van for high risk groups, tele-counseling and counseling centers for general population.

5.6 DONORS AND INTERNATIONAL ORGANISATIONS

India receives technical assistance and funding from a variety of donors. Donors are The World Bank, DFID, USAID, CIDA and BMGF. Other more recent donors are DANIDA, SIDA and the Clinton foundation. Besides above donors, NACO also partners with The United Nations Programme on HIV/AIDS (UNAIDS) and its nine co-sponsors- UNICEF, ILO, UNDP, UNFPA, UNESCO, WHO, UNDCP, WFP and The World Bank.

5.7 GOVERNMENT/PUBLIC/PRIVATE/CORPORATE SECTOR

The role played by various government/public/private sector institutions has been given below[102]:

Name of the Institution	Relation with NACO	Role Played
Ministry of Defence	Facilitated by NACO	Prevention among the Armed Forces; Capacity building of medical and paramedical professionals to provide diagnosis and treatment
Ministry of Railways	Facilitated by NACO	Prevention among the railway workers and their family members. Capacity building of medical and paramedical professionals to provide diagnosis and treatment; provision of VCTC
Ministry of Youth Affairs	Facilitated by NACO	Universities Talk AIDS (UTA) for college youth programme and Villages Talk AIDS (VTA) programme for out of school youth.
Social Justice and Empowerment Department	Programme Integration	Drug-De-Addiction-cum-Rehabilitation Centers and Counseling Centers
ESIC	Programme Integration	Service provision through their network of institutions
Voluntary Health Services	Programme Implementation	USAID funded APAC and capacity building of SACS and TRG for TI BMGF funded TAI (CSW, MSM and IDU) in Tamil Nadu
AVERT	Programme Implementation	USAID funded HIV/AIDS programme in Maharashtra
Corporate Sector	Miscellaneous programmes	Work Place Prevention programme; ARV availability at reduced cost-pharma; STI Clinics; Advocacy
BMGF	Programme Implementation	AP, Tamil Nadu, Karnataka, Maharashtra, Manipur, National Project for Truckers, Research and Technical Support

5.8 Findings and Recommendations

No interventions have yet been started in any of the study areas except the fact that one TI programme for CSWs in Dungarpur (Rajasthan) partially covered tribal women involved in selling sex to truckers on highways; migrant tribal people who were living in urban areas were covered by ongoing intervention programme in West Bengal; interventions were ongoing for migrant workers and CSW in some tribal mandals in AP. Similarly, in Manipur rapid interventions and care projects covered tribal population. VCTCs in low prevalent states are not available in tribal pockets. VCTC in tribal area in Thane of Maharashtra has been recently started and counselors have not been given training as yet. Care and support centres were not reported in any of the tribal pockets covered under study. The following are the recommendations arising out of the Institutional Analysis:

[102] NACO Annual Report 2002-03; 2003-04 : 19

- A special function at the National and State level needs to created and positioned to deal with issues relating to policies, coverage and implementation of interventions among the tribal people and other socially disadvantaged sections of the population who are vulnerable to HIV
- The district level planning envisaged during NACP III phase III needs to identify the vulnerable and socially disadvantaged populations as well as the tribal population that need to be covered in the different districts of each state
- The Governing Board and Executive Committee of each SACS can be expanded to include members from the Social Welfare Board and Tribal Development departments for better understanding of the requirements of the populations and appropriately plan for intervention and services in those areas
- The convergence with RCH II especially in the areas of Tribal Plan, Urban Poor and the approaches to mainstreaming gender and equity can be attempted in order that the service availability and service provision can be linked. The policy and goals can be studied and the same be tied up with in the state PIP for serving the tribal population and other marginalized and socially excluded population
- Behavioral studies using a ethnographic approach needs to be carried out in different tribal and rural belts to better understand the risk and vulnerability factors of the specific population in order to design programmes and interventions for these populations
- Capacity building of the NACO and SACS staff on the Social Development issues, gender, equity and Social Exclusion needs to be provided in order that the staff are sensitized and appreciate the necessity to include and mainstream such aspects into the programme.
- District level structures need to be created for planning the district level HIV/AIDS intervention with evidence for planning and capacity needs to be built on different aspects of programme planning and management

Chapter 6

RECOMMENDATIONS

In light of above findings, the following key recommendations may be considered at national, state, district and community level.

National level - Policy Related

1. Multi-pronged approach may be adopted to reach out tribal people. GOI's special provisions in tribal sub plan areas include additional health facilities. The health workers in these facilities may be trained to be responsive to the tribal, provide them counseling on HIV/AIDS and it will help identify tribal volunteers who will ensure response to the tribal keeping in view the World Bank Guidelines given in Operational Policy and Bank Procedures 4.10.

2. Considering the vulnerability and risks associated with the tribal population at the National level a policy decision regarding the necessity to intervene with this group needs to be taken. The states need to be informed of this priority and enabled to develop district plans.

3. Convergence as a strategy needs to be initiated in order to bring about and derive advantages of the synergy between NRHM and the HIV/AIDS programme, and can commonly address the issues of:

    - Difficult terrain and sparsely distributed tribal population in the forest and hilly regions
    - Locational disadvantages of Public Health Institutions in tribal areas
    - Weak primary health care infrastructure including diagnostic equipment
    - Vacant positions at Public Health Institutions
    - Non-availability of staff for supervision and monitoring
    - Effective IEC using relevant dialects/languages
    - Involvement of faith healers/traditional healers and other non-qualified private practitioners in whom the tribal people have faith
    - Improvement of drug logistics and availability

4. Recognizing the importance of Social development issues it is necessary to create a function of Social development within NACO and SACS to be able to address these issues in programme planning and implementation; and to identify, assess and design interdisciplinary research priorities and actionable knowledge strategies within SACS and NACO.

National Level – Programme Related

5. Request the states to carry out a mapping exercise in order to identify tribal belts as well as gather information regarding the prevalence of STI and HIV through the sentinel surveillance surveys in order that adequate disaggregated information available on the tribal population. The National Behavioural Surveillance Survey can include variable which enables analysis by social groups.

State level

6. Convergence between NRHM and HIV/AIDS control programme should be brought about at the state level as well where the SACS need to interact with State Rural Health Mission. It may be useful for the State Supervisory Bodies (governing and executive committee) to be more representative of the stakeholders, certain departments and organizations like social and tribal welfare, representatives of PLHA networks and NGOs and Adivasi networks.

7. There is a need to have a communication strategy on stigma, discrimination, care and support more clearly. Messaging on VCTC, PPTCT and other routes of transmission, preventive methods other than condom may be considered. State may be provided resources to localize the contents in local dialect of tribal.

8. The findings with regard to vulnerability of tribal people suggest that there is a need to collaborate or co-ordinate with Department of Tourism (Rajasthan and Andhra Pradesh) as the tourists are involved in sexual activities with tribal women. The programme managers may sensitize the department with the existing problems and seek co-operation for promoting preventive services.

District Level

9. At district level or below, there is no disaggregated data on prevalence rates for different social groups. Also there is very little known about the various social groups other than the HRGs and vulnerable groups already identified. It is, therefore, suggested that the programme should address this gap.

10. There is need to initiate focused intervention for tribal group. The beginning could be made through;

- Establishing VCTCs and sentinel sites in the tribal dominated pockets. VCTCs may be established at CHC level.
- Identifying NGOs who are willing to work with tribal people. Some NGOs (like NATURE in Vizag and Vagadh Vikas Sansthan in Dungarpur) already working with tribal people may be identified as nodal NGOs and some other NGOs active in tribal areas even on non HIV issues and those who have showed their willingness to work on HIV issues (e.g. Kalyan in Purulia) among them may be associated with these nodal NGOs in order to reach out tribal people.

- Encourage government doctors and Para health staff to serve in tribal and difficult areas by providing them facilities like transport, substantial educational allowance, housing allowance etc.

Public-Private Partnership

11. A detailed assessment of the corporate sector that uses the skills of tribal people and attracts them for employment can be listed out and these institutions can be oriented to the issue of HIV/AIDS and collaboration sought with them for the Corporate Sector involvement in the prevention and education programme as well as in provision of services such as STI.

12. Apart from convergence of HIV/AIDS control programme with NRHM for the service delivery to tribal people, Advocacy for participation of development and private sector agencies and liaison with international and national agencies engaged in developing sustainable livelihoods and reducing vulnerability also need to be thought about.

Further Research Areas

- Specific tribes of Orissa, Madhya Pradesh (specifically Bastar) Lakshadweep, Nilgiri hills, Uttaranchal etc to be studied separately
- Detailed mapping of tribals needs to be undertaken
- Suggestion for carrying out more anthropological studies among specific tribal groups

ANNEXURES

ANNEXURE 1.1: Description of NACP

NATIONAL AIDS CONTROL PROGRAMME

India's official response to the HIV/AIDS epidemic took shape in 1992 with launch of the first National AIDS Control Project (NACP 1), funded primarily by The World Bank IDA Credit. Highlights of the first phase included;

- Establishing an administrative and technical basis for program management
- Strengthening of sentinel surveillance systems, installation of VCTCs
- Stepping up awareness generation activities and advocacy efforts towards HIV/AIDS
- Modernization of blood banks
- Strengthening the management and treatment of STIs and promotion of condom use

While significant progress was achieved in building some capacity at state levels, there remained certain limitations in the implementation of NACP-I. These related to the uneven implementation of project activities at state-levels; inadequate information regarding the progress of the epidemic because the sentinel surveillance could not be conducted across all states, all vulnerable groups were not identified, issues surrounding care and support of people living with HIV could not be fully addressed and IEC remained somewhat limited, and community involvement was inadequate.

Learning with the experience of Phase-I, there was a paradigm shift in the Phase-II of the project addressing larger issues in prevention and control of the epidemic. With the two key objectives of 1) reducing the rate of growth of HIV infection in India; and 2) strengthening India's capacity to respond to HIV/AIDS, NACP-II (1999-2006) aimed at decentralization and state ownership, a focus on vulnerable groups, from mass awareness to behavior change, NGO & Community participation, Care & support to PLHA and a rights based approach, participation of non health sectors and the commitment of adequate resources.

NACP II had two components with appropriate interventions defined[103]:

- Delivering cost-effective interventions to contain the spread of HIV/AIDS through
    1. Targeted interventions for groups at high risk
    2. Preventive interventions for the general community, and
    3. Low cost AIDS care

- Strengthening capacity through

    1. Institutional strengthening
    2. Inter-sectoral collaboration (public, private, and voluntary)

Accordingly, it set out to keep HIV prevalence below 5 percent among the adult population in high prevalence states, below 3 percent in moderate prevalence states and between 1 and 2 percent in low prevalence states. It also aimed at raising awareness levels among 90 percent of youth and people in reproductive age group, and achieving 90 percent condom use among high risk groups[104]. To achieve these aims, the focus of NACP-II was on sustained behavioural change rather than raising awareness. It decentralized program delivery to the states and making it flexible, evidence based and participatory. The components of NACP-II have been illustrated below[105];

[103] NACO Annual Report 2002-03; 2003-04 : 12-91
[104] National Planning Team, NACO, MOHFW, GOI (2005): NACP Phase –III: 2006-2011- Draft Strategic Framework:7
[105] NACO Annual Report 2002-03; 2003-04 : 12-91

Specific components	Brief Description
SURVEILLANCE	
Evidence Based Planning	
Annual Sentinel Surveillance	HIV sentinel survey has been institutionalised over the years in order to monitor trends of HIV infection in specific high risk groups (people attending STDs clinics, MSM clinics, drug de-addiction centres) as well as low risk groups (mother attending ANC)
AIDS Case Detection	AIDS is increasingly affecting young people in sexually active age group. Predominant mode is heterosexual contact. The ratio of male/ female AIDS cases is 3:1. TB is most predominant OI among AIDS patient.
Mapping of High Risk Groups	Vulnerable population is mapped in order to identify location, size and trends in movement. Every NGO is expected to conduct needs assessment in their proposed area of intervention.
Behavioural Surveillance	Realizing the need for accurate behavioural data, one round of behavioural surveillance has been completed across high risk groups and the general population in all states and UTs.
PREVENTION	
High Risk Populations	
Targeted Interventions	This component aims to interrupt HIV transmission among highly vulnerable populations (sex workers and their clients, IDU, MSM, truckers, migrant workers and street children). The rationale for TIs includes directing HIV prevention efforts among groups with a high rate of partner change, whether sexual or needle sharing partner, is a proven cost effective strategy as it has the multiplier effect of preventing many subsequent rounds of infection.
STD Treatment	An individual with STI is 8-10 times more vulnerable to contracting HIV. Hence controlling STI will help reduce the incidence of HIV. BSS illustrated that less than 20 percent of those suffering from STIs seek treatment through government clinics in most states of India. Perceived lack of confidentiality and the stigmatization of those with STIs, drive the majority to the private health sector, and /or to unqualified practitioners or quacks with home remedies. Services for STI treatm3nts are being delivered through STI clinics. One STD clinic in each district hospital and medical college. STD clinic provide consultation, lab investigation, counseling and treatment while maintaining privacy and confidentiality.
Condom promotion	The programme messages on correct and consistent condom use as one of the important HIV prevention method. Condom use provides dual protection- protection from disease (STI/HIV) and averts the unintended pregnancies. SACS distribute condoms, free of cost at all high risk sites.
Intersectoral collaboration between public private and voluntary sectors	NACO facilitates the involvement of various sectors such as education, defence, labour, youth affairs, steel, railways, industry and transport, rural development, social justice and empowerment to optimize India's response to AIDS. To ensure sustainability, NACO promotes HIV/AIDS prevention and care activities into the ongoing governmental programmes of the government.
Training of medical and paramedical personnel	Separate training modules have been developed for different health functionaries at the primary, secondary and tertiary levels of health care. Training institutions have been identified, and senior faculty members of medical colleges form a resource network at the national, state, and district level to build capacity of the health functionaries at different levels.
Low Risk Populations	
Holistic IEC and social mobilization	At national level, NACO is responsible for policy and strategy formulation and for framing guidelines for IEC activities. Advocacy with the elected representatives and with the media, inclusive of the regional media and the vernacular press receives special focus at the national level. At state level SACS conduct CNA studies to enable to evolve state specific IEC strategies that address local priorities.
Blood safety	NACO articulates policy and the operational strategies for a country wide programme on blood safety, supports strengthening of infrastructure and ensures quality in all aspects of service delivery.

Specific components	Brief Description
Voluntary Counseling and Testing	VCT is a key entry point for a range of interventions in HIV prevention and care, like preventing HIV transmission. From mother to child during childbirth, referrals for STD treatment, condom promotion.
AIDS vaccine initiative	For the purpose, there is tripartite MOU between NACO, ICMR and the non-profit IAVI. Potential Indian Manufactures for the AIDS vaccine have been meticulously reviewed, and the most appropriate among them identified.
Sensitizing young adults	NACO reaches out to youth through a variety of special programmes- School AIDS Education Programme, Initiative for university students, initiative for rural youth.
Workplace intervention	To strengthen the response to HIV/AIDS at workplace, NACO is collaborating with ILO, Ministry of Labour, industrial associations and private sector enterprises and voluntary organizations. The workplace programmes are doing advocacy for strengthening the world of work response to HIV/AIDS based on the principle of the ILO Code of Practice on HIV/AIDS and world of work.
CARE	
Low Cost Care & Support	
Prevention of perenatal HIV transmission	Perenatal HIV transmission can occur during pregnancy, at the time delivery or through breast feeding. Parent to Child Transmission (PTCT) of HIV can be prevented with a combination of low cost, short term preventive drug treatment, safe delivery practices, counseling and support
Management of HIV-TB co-infection	TB is most common Opportunistic Infections (OI) among those living with HIV in India. NACO expanded the mandate for care and support of PLHAs by linking services for voluntary counseling to the microscopy centres set up under the revised national TB control programme to improve access to free treatment for the HIV-TB co-infection. A Joint Action Plan enables the developing of linkages between the TB microscopy centres of the RNTCP and VCTCs of NACP, at district and sub district level. NACO conducts joint training of doctors, health workers and NGOs for management of HIV-TB co-infection, in six high prevalence states.
Treatment of opportunistic infection	NACO ensures the availability of essential drugs for opportunistic infection. The SACS funds the treatment of OIs in government run hospitals up to the district level.
Piloting ART	NACO provides ART at government hospitals, free of cost, for people living with HIV/AIDS in 6 high prevalent states.
Post exposure prophylaxis	NACO also provides PEP in all government hospitals admitting PLHA. These provide protection for HCPs in the event of needle stick injury.
Community care centre	NACO support Community Care Centres (CCC), drop in-centre and supports groups of PLWHA. These centres provide peer counseling and referrals for health care.

Currently, even as NACP has made a major breakthrough in the management of the epidemic at the state and local levels, HIV continues to be concentrated amongst the poor and marginalized sections of society, including female sex workers, injecting drug users, men who have sex with men and migrant laborers. HIV is spreading beyond "at risk" groups to the general population, and from urban to rural areas[106]. The number of women infected is steadily rising: one in every four AIDS cases reported is a woman.

The preparatory steps towards developing the design for NACP III (2006-2011) are currently being undertaken by a planning team. Towards making the program development as consultative as possible, necessary constituencies have been identified amongst whom consultations will be held. The team recognized that for designing NACP-III, the available knowledge and expertise would be harnessed. For the purpose, several theme based working groups have been constituted to collate the lessons learnt from NACP-II, analyse the present situation and suggest future directions[107].

[106] NACO Annual Report 2002-03; 2003-04 : 14
http://www.nacoonline.org/annualreport/annulareport.pdf.
[107] Working Group Reports for Design of NACP-III 2005-06:1

ANNEXURE 2.1: METHODOLOGY

The research methodology employed in this assessment was qualitative in nature. Group and one to one discussions were conducted with the primary stakeholder's i.e. tribal people. PRA techniques like social mapping and chapatti diagramme was also used to understand the local dynamics. In-depth interviews with implementers/service providers/researchers (SACS, DACS, NGOs, health care providers and academicians) were also conducted. The following research tasks were undertaken to accomplish the objectives.

Research Tasks

Tribal Assessment consisted of the following research tasks:

Task 1	Literature Review
Task 2	Conducting primary assessment among tribal groups selected districts of India and consultation with key target groups, health care and service providers, implementers etc
Task 3	Preparation of recommendations

Task 1 : Literature Review

This task was intended towards analyzing information on tribal population and issues addressed by various relevant studies /research papers prepared under the auspices of NACO, UNAIDS, RCSHA, FHI, NGOs and studies conducted by ORGCSR and tribal research institutes/academicians.

The literature collected during the course of assessment included working group reports for the design of NACP-III, research papers, conference reports, guidelines, research studies reports, discussion papers, workshop reports, state mapping reports, annual reports and evaluation reports, behavioral surveillance survey reports, website material, tribal development plan documents and a few research papers on tribal population in India. These were collected from various sources such as NACO, UNAIDS RCSHA, FHI, and NGOs and also from studies conducted by various research agencies including ORGCSR on the tribal population. Reports and documents were also gathered from the assessment states and the districts. Review was also done from the literature available on the internet. The collected study reports included CNA, mapping reports, research thesis, annual reports, list of NGOs, district maps indicating health facilities, draft PIP documents of some of assessment states , IEC material, etc. The findings of review of literature collected have been integrated with the findings of primary research. During our efforts for the collection of studies, it was observed that the material for the review on the tribal population was scarce and not easily available as anticipated. The researchers had to use snowball technique to collect the material especially at the state level and below. The review looked at both the community as well as the programme perspective, specifically in relation to the following aspects.

Specific issues	**Description of information collected**
COMMUNITY PERSPECTIVE	
Basic information on tribal communities	
• Tribal demography	Tribal population, number of tribes, major concentrated areas,
• Standard of living	Data on TV viewership and radio listnership in rural areas of country.
• Health and educational status	Educational level
• Major occupations	Occupations during peak and lean periods, migration
• Gender roles/barriers	Gender biasness in treatment seeking
• Decision making processes	Decision making in the family with regard to treatment seeking (place, type and timing of seeking health care)
• Marriage systems and sexual practices	Marriage systems, age at marriage, separation sexual practices, and opportunities made available to youth to mix with opposite sexes like fairs, melas etc, and financial independence of couples.

Specific issues	Description of information collected
Socio economic factors making the tribal and other communities more vulnerable	
Health care services and health seeking behavior	
• Awareness/Utilization of health facilities	Problems related to accessibility and utilization of health services by tribals
• Health seeking behavior	Health seeking behavior of tribals,
Knowledge, Attitude and Practices	
• Awareness of HIV/AIDS	HIV/AIDS awareness among women and by caste- SC,ST, General caste. Sources of awareness for tribals. Awareness of HIV/AIDS among rural and urban population, awareness of modes of transmission by gender Awareness of HIV/AIDS among tribals and rural communities.
• Awareness of STI	Awareness of STDs among General Population and tribals
• Causes of vulnerability	Causes of social and STI vulnerability (bride price and financial burden , commercial sex) Causes of social and HIV vulnerability
• Sexual practices	Village dormitories or ghotul, Trade of tribal women in sexual, Attitude towards premarital sex, Indulgence of tribal women in extramarital sex, Multiple sexual relations in rural communities, Median age at first sex among general population, Special ethnic and religious groups involved in sex work among non-tribals, Devdasi system among some ethnic groups, Involvement of tribal people with high risk groups and other vulnerable groups, Condom use among IDUs, HIV prevalence among IDUs
• accessibility to information and barriers faced, misconception about HIV/AIDS/STIs	Proportion of general population visiting government facilities for STI treatment
• treatment seeking behavior for STIs, stigma and discrimination surrounding HIV/AIDS	Treatment seeking behavior of tribal women, Reasons for contracting RTIs among women
• attitude towards HIV/AIDS patients	Attitude of community and health workers
• misconceptions regarding treatment and care and high risk behavior (use of condoms)	Misconceptions about transmission modes
Exposure to mass media	
• Mass media exposure (Electronic, print, IPC and folk media)	Accessibility to electronic and print media, IPC, entertainment education
• Effectiveness of IEC messages and the various channels in different population groups	Communication strategy and information seeking behaviour
PROGRAMME PERSPECTIVE	
Institutional arrangement	
Existing strategies	Communication strategies from CMS study, Monitoring and capacity building strategies details were gather from State PIPs
institutional arrangements/mechanism currently in operation to combat HIV/AIDS at various levels	Various institutions involved in implementation of NACP at district, state and national level
Informal and formal institutions and	Information gathered through primary assessment
Networks involved in implementation of HIV/AIDS programme	Information gathered through primary assessment

Specific issues	Description of information collected
Policy and Legal Framework	National HIV/AIDS Control Policy, National Health Policy 2002, National Population Policy 2000, national HIV Bill, national Rural Health Mission, National RCH and RNTCP Programme, existing legal policies on various social groups and Gaps

Task 2:

(a) Conducting primary assessment among tribal groups

(b) Consultation with health care providers and implementing agencies

In this task, an assessment of the actual situation (including HIV/AIDS prevalence, sexual practices and behaviors, access to IEC, PDTC services) among tribal people in selected states has been undertaken. Simultaneously, a team of research professionals conducted consultations with implementers, health care providers, NGOs, academicians etc to validate and expand the information collected through primary research.

Task 2 comprised of two sub tasks: (1) An assessment of HIV/AIDS prevalence in assessment area in general and among tribal in particular and 2) Assessment of actual situation with regard to sexual practices and behaviors, access to IEC, PDTC among tribal people in selected states.

To achieve this sub-task-1 in an optimal manner the following methodology was adopted.

- Since HIV prevalence data specifically for tribal population was not available across the assessment states, the same was collected for the entire assessment district and or state from SACS office.

- The data was further validated through discussion with VCTC in charge of respective assessment district.

For sub task 2, mainly qualitative research technique was employed to collect the necessary information from the tribal people. Wherever required; the information pertaining to tribal people was compared with data collected during National Baseline General Population BSS i.e. data on non-tribal people.

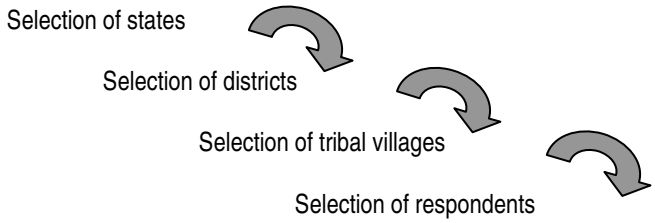
Under task 2, for consultations, in-depth interviews were conducted with community leaders, NGO/CBO/VO, academicians, health practitioners, SACS and DACS officials.

Task 3: Recommendations

Based on the gleanings of the above two tasks, a set of recommendations have been given.

Selection procedures

The tribal areas were selected involving four stages:



Selection of states

Keeping in view the assessment objectives, six states comprising high risk states, states neighboring high risk states or states witnessing in-migration and out-migration were covered. These were Chhattisgarh and Rajasthan in the North; Andhra Pradesh in the South; Maharashtra in the West; and West Bengal and Manipur in the East/North East Zone were covered.

Selection of districts

The criteria that were followed for selection of districts were as follows:

- ❒ The district should be a high-risk district in terms of HIV/AIDS prevalence or adjoining a high-risk district/city from where considerable in and or out migration would take place.
- ❒ The district should have considerable tribal population

From each state, one district satisfying the above criteria was selected. The rationale for selecting states and districts for the primary tribal assessment are given in the following table.

Table 1: Assessment States and Districts

State	Districts	Rationale
North Zone		
Chhattisgarh (39.7%)	Raipur (17.4%)	Chattisgarh has considerable tribal population and it borders high-risk states of Maharashtra and Andhra Pradesh. Raipur is the State HQ and an urban industrial area. Tribal/rural populations in Raipur being closer to industrial urban belt were perceived more vulnerable.
Rajasthan (16.4%)	Dungarpur (70.4%)	In-migrants and out migrants make Rajasthan more vulnerable. Dungarpur being dominated by tribals and situated on national highway was perceived highly vulnerable.
South Zone		
Andhra Pradesh (9.1%)	Visakhapatnam (24%)	Andhra Pradesh and Vishakhapatnam are both identified as high-risk areas as per NACO classification. Vishakha patnam has a considerable tribal population also.
West Zone		
Maharashtra (15.4%)	Thane (53.8%)	Maharashtra and within Maharashtra, Thane have been identified as high prevalence and high-risk areas as per NACO classification. Thane has considerable tribal population also.
East/North East Zone		
West Bengal (7.6%)	Purulia (20.3%)	West Bengal has common international borders with Bangladesh Bhutan and Nepal. Rich agricultural and industrial base attracts lots of population within and outside the state, making the state population quite vulnerable to HIV/AIDS/STI. Purulia has considerable tribal population.
Manipur (46.5%)	Churachandpur (93.2%)	Manipur and Churachandpur both are identified as high prevalence and high-risk areas as per NACO classification. Churachandpur has considerable tribal population.
Total	6 districts	

** Figures in parenthesis show % of tribals to total rural population of the assessment area*

Selection of villages

Purposive selection of villages was done at the district level. Villages with considerable tribal population (75% above) and where from large number of people particularly males migrate temporarily to neighboring high risk districts/cities or falling on the National Highways (few samples of other vulnerable groups such as truckers/transport workers) or from those villages with considerable tribal population and where at least one tribal PLWHA/STI was present as per the records maintained by the DACS/VCTC functioning at the selected district hospital were selected. Care was taken to represent different distances from the district HQ. In all 5 villages were assessed per district. The actual procedure followed in selection of the villages in different districts was as follows:

- In Dungarpur (Rajasthan), information on HIV patients [tribal] coming from different tribal villages of the assessment district was available from VCTCs and DACS offices. While selecting villages, inputs were also sought from NGO working in HIV/AIDS in the district. To ensure proper geographical representation of the district/blocks therein, district health map obtained from District Programme Manager (RCH) at CMHO office was utilized. In Dungarpur, the randomly selected five villages were spread across 4 blocks.
- In Churachandpur (Manipur) also it was possible to collect information on STI cases [tribal] coming from different tribal villages of the assessment district from DACS office and NGOs. This helped in selection of the villages. In Churachandpur, the selected five villages were spread across 3 blocks.
- In Thane (Maharashtra), the information on HIV cases coming from tribal area was not available with VCTCs situated at the district Hospital of Thane and Jawahar Taluk. The information on the same was obtained from rural hospital of Talasari taluk, through the records of Blood donation camps. Since most of the HIV positive cases were reported from Talasri taluk, all the five villages were selected from Talasari taluk only. Also Talasari is a Taluk next to Vapi-Virar Mumbai Highway and Talasari Chroti crossing was selected by MSACS during their intervention with truckers in 2000.
- In Raipur (Chhattisgarh), since information on the tribal villages reporting cases was not available either from VCTC or STD clinic situated at Jawaharlal Nehru Medical College, tribal blocks were identified in discussion with District Programme Manger (RCH). There are three tribal blocks in Raipur. Five villages where from people make temporary migration or travel to city area, were selected across the three blocks.
- In Purulia (West Bengal), most of the cases at VCTC were from the urban areas or rural areas near the Purulia town. Some cases were also from the neighboring districts of Bankura. No major trend with respect to higher number of cases from pre-dominant tribal blocks was observed. Information with respect to the blocks in which the tribal populations were predominant and the villages where these were present in majority, was sought from Tribal Welfare Office. The village selection was done keeping in mind the coverage of maximum number of blocks, adequate representation of all predominant tribes and villages with majority of tribal population. Five villages were selected across four blocks.
- In Visakhapatnam (Andhra Pradesh), based on VCTC (Araku Valley) register, 8 villages from where HIV cases were reported were listed and three of these were selected. The remaining 2 villages were selected from the census data. The reason for selecting these two villages was that the majority people who visit VCTC were referred by NGOs. It was felt that there should be some representation of the tribal villages where there is no presence of NGOs but some of the visit to city side frequently. In all five villages were selected across 5 Mandals.

Selection of respondents

In each selected village, one FGD and two IDIs were conducted among tribal people. In all, 5 FGDs and 10 IDIs were conducted per state. Five FGDs in each state were conducted among the following categories;

FGD 1: Married, male (25-49 age group)
FGD 2: Unmarried, male (15-24 age group)
FGD 3: Married, female (25-49 age group)
FGD 4: Unmarried, female (15-24 age group)
FGD 5: repeat any of the above

Similarly, two IDIs, one with male and another with female members was conducted. The recruitment process of participants for FGDs has been described in subsequent section.

Operational Aspects of the primary assessment and consultations

This section details out the approaches the researchers adopted to conduct the primary assessment and the consultations. Since the assessment is largely based on consultations at various levels i.e. at the implementers level (SACS and DACS), at the service providers' level (NGOs, private practitioners, traditional healers), at the intellectual level (academicians) and at the community level (community leaders and the communities themselves), it is very important to delineate how the researchers went about contacting them. These processes will provide useful insight for the policy planners and programme managers in actually designing interventions.

Consultations with SACS

At the outset, the assessment team had discussion with PD, SACS/Asstt. PD, SACS and NGO advisor to gather information on the strategies adopted by SACS to implement the entire programme in the respective states. These discussions covered details on communication campaign, identification of high risk populations, planning of targeted interventions and other approaches addressing PDTC in the entire state and in the assessment district. A discussion guideline was used for ensuring coverage of all relevant issues. The consultation with SACS helped the team in identifying the NGOs and other stakeholders who can be invited for the workshops. Contacting the officials at the SACS took more time than anticipated and delayed the work to some extent. Taking appointments of SACS/DACS officials in some of the states proved to be a very time consuming exercise. Moreover the newly appointed officials at some of the SACS could not contribute much to the assessment.

Consultations with DACS

At this level, information obtained at state level about the district was further expanded and strengthened. The main focus was to understand the local scenario with respect to tribal areas vis-à-vis the entire programme implementation, special efforts taken to cover tribal people, ethnographic profile of tribes, NGO/CBO/VO working with them, impact and constraints issues etc. Mapping of stakeholders/beneficiaries, implementers, health care providers, NGOs, academicians etc remained an integral part of these discussions. Efforts taken with respect to prevention, diagnosis, treatment and care at the district level for tribal population were also documented. The team also enquired about the other vulnerable groups identified in the district (other than high risk groups). Since the present assessment mainly focused on tribal population, this report provides a detailed account of tribal groups and makes a reference to other vulnerable groups. The team, in consultation with DACS, also identified NGOs who can be invited for the workshops.

The profiles of the officials holding charge of the HIV/AIDS programme differed from one assessment district to another. In Dungarpur (Rajasthan), Principal Medical Officer (PMO) looks after HIV/AIDS programme. In Raipur (Chhattisgarh), Asstt. Civil Surgeon holds charge of HIV/AIDS programme at district level. In Visakhapatnam (Andhra Pradesh) and Churachandpur (Manipur), District Leprosy Officer (DLO) is the nodal officer for district HIV/AIDS Control Programme. In Purulia (West Bengal), District Chief Medical Health Officer (DCMHO) is responsible for district HIV/AIDS Programme. In Thane (Maharashtra), a medical officer (Dentist) is in charge DACS official. While most of the above officials could be contacted during the assessment, in places like Purulia and Raipur, the research team had to be content with discussions with in-charge DCMHO and CMHO, respectively as the district nodal AIDS officer were not available.

VCTCs at district level were also visited to collect information on vulnerable tribal villages. However, these visits did not yield much useful results in this regard (with an exception of Dungarpur and Visakhapatnam VCTC) due to non-existence of VCTC or non-availability of data trends on tribal HIV patients. In case of Dungarpur, while collecting information on the vulnerable tribal areas from the VCTC, case reports/general profile of HIV positive people coming from tribal areas could also be obtained to understand the causes of vulnerability.

Interaction with Community and consultations with community leader

At the beginning, in each selected village, the assessment team met the local leader (Sarpanch) to brief him about the objectives of assessment, to seek his permission for social mapping of village and to conduct group discussions among community members. This helped building rapport with him and subsequently with the community. In order to prepare social map of the village 1-2 youth/persons from the village who were well versed with the village as well as the adjoining areas/communities were identified and their help was taken to chalk out the map of the village and the adjoining areas. The team members along with these two community members had a transact walk through the village and prepared a map to indicate the boundaries and divisions of the settlements of different population groups, shops, agricultural areas, health facility, schools, highways and public transportation arteries and residential areas, hotel/dabha, CBO, temples, banks, religious centres, co-operative, panchayat ghar, bus stand etc.

With the help of local leader (sarpanch), married and unmarried male members (8-10 members) of specified age groups (15-24 and 25-49 years) were called in at a fixed up place (mostly village choraha, community leader's backyard, etc) for the discussion. The researchers could retain the group for about 1- 2 hours discussion. Similarly, anganwadi workers helped in arranging female groups for discussion. While recruiting respondents the specified age groups and marital status was kept in view. Two members (one moderator and one facilitator) conducted the discussion. The team members took extra care to make the discussions participatory. Using one of the PRA technique

(Chapati diagramme), attempts were also made to identify those individuals/institutions who were important and more important; influential and more influential for the community. A detailed discussion guideline was used during the discussion. The entire discussion was recorded through tape recorders. The team members also took notes of important issues covered.

It was not possible to explore issues related to sexual practices and personal incidences of STIs in groups, and hence two IDIs were also conduced in each village (one each with male and a female member). These IDIs were conducted with members who were not covered during group discussion.

In all, 15- 20 members were contacted in each village. It is important to mention that the field teams had prepared field notes on routine basis during the course of fieldwork. The issues covered in the field notes included the physical issues (e.g. distance and time taken to reach village, connectivity etc), dynamics that will have impacts on the programme (local belief, treatment seeking etc), underlying reasons of vulnerability (occupation, migration, commercial sex, alcoholism, poverty, etc).

Consultation with community leader / traditional healer / NGOs / private doctors / academicians

In-depth discussions were conducted with the community leader and traditional healers at the village level. Private Doctors including STI specialist could be contacted at all level i.e. village, taluk and the district level. NGOs and academicians could be contacted only at district or state level. The purpose of conducting interviews with the health service providers, implementers and academicians was to validate and expand the information collected from community members with respect to their culture, knowledge, attitude and practices towards general health illnesses, STIs, health seeking behavior etc

Interaction with high-risk groups

During assessment, attempt was made to contact some high-risk groups who were associated with tribal communities. For instance, In Dungarpur, a few tribal women were involved in selling sex to truckers. Therefore, in depth discussion was conducted with tribal women as FSW and with truckers as clients of sex workers. Similarly in Visakhapatnam, some tribal women and some tribal motor drivers were interviewed as FSW and clients of sex workers, respectively. In Churachanpur, tribal people were reported to be FSWs, IDUs and MSMs and hence were interviewed. In Purulia, Thane and Raipur, presence or association of high-risk groups was not reported among the tribal people.

Number of Interviews conducted

Table 2 given below presents the number of interviews covered at community level across the six assessment areas.

Table 2 – Number of discussions and interviews conducted among tribal people

State	Districts	FGD among tribals	IDIs Among Tribals
North Zone			
Chhattisgarh	Raipur*	5	10
Rajasthan	Dungarpur	5	10
South Zone			
Andhra Pradesh	Visakhapatnam	5	10
West Zone			
Maharashtra	Thane	5	10
East/North East Zone			
West Bengal*	Purlia*	5	10
Manipur	Chura chandpur	5	10
Total	**6 districts**	**30**	**60**

Table 3 given below presents the number of interviews conducted for consultations across the six assessment areas

Table 3 Achieved Sample Size for Consultations

Secondary stakeholders	Achieved Sample in All States
IDIs among secondary stakeholders	
SACS	6
DACS	6
Community Leader	6
NGOs	18
IDIs with Health care Providers	
Private Doctor	6
Traditional Healer	5*
STI Specialist	5**
IDIs with Academicians	**5***
HRGs (available in assessment **areas)**	**14*** **
Total	**57**

** Not available in assessment areas in Manipur*
*** Not available in assessment areas in Andhra Pradesh*
**** 6 among FSWs, 4 among clients of FSW, 2 among MSMs and 2 among IDUs*

ANNEXURE 2.2: LIMITATIONS

The assessment faced several limitations from the point of its design. Most of these related to the following:

- The literature on tribal population with respect to HIV/AIDS is scarce
- The researchers had to put in a good amount of time to obtain appointment from the SACS officials.
- In some of the SACS officials were newly appointed and could not contribute much in the assessment.
- During consultations with SACS and DACS the tribal populations (especially in Raipur and Purulia) were reported to have low STD/HIV prevalence. This had implications on the selection of the tribal villages for the assessment as the assessment had planned to identify tribal villages reporting higher incidence of STDs/HIV. Another major problem in this regard was the faulty addresses that the patients had given at the VCTCs. With this apprehension in mind the assessment team in some states had to resort to identifying villages with higher tribal populations to conduct consultations, FGDs and in-depth interviews.
- The data collection was delayed in Manipur, as the selected district – Churachandpur is a politically disturbed area.

ANNEXURE 3.1: STATE PROGRAM- RAJASTHAN

RESPONSE OF SACS AND DUNGARPUR DISTRICT OFFICIALS

First HIV case was detected in Pushkar in 1987. In 1992, State Government set up a State AIDS Cell in the Directorate of Medical & Health Services, Govt. of Rajasthan, Jaipur to implement prevention activities. In 1998, Rajasthan State AIDS Control Society came into existence in 1998 under Rajasthan Society Act 1958 to implement NACP in the state. The state government also responded to epidemic by establishing anti-discrimination cell, contribution from the CM's fund for HIV programme, anti-discrimination policy, and executive committee of RSACS to provide oversight and directions to NACP etc. RSACS, based on the gaps identified during NACP-II, has already submitted their PIP for NACP-III.

It was observed that at the district level (Dungarpur) low importance was given to HIV/AIDS programme. The deserved priority could not be given to the programme because the district level functionaries like CMHO, PMO at district hospital have been given the charge of the programme as an additional responsibility. The primary role of district level functionaries is to build capacity of paramedical staff and anganwadi workers at the grass roots level and to organize awareness campaigns for both urban and rural population including tribal people. It is appropriate to mention that 65% of Dungarpur district population is tribal.

HIV prevalence rates in the state

Till March 2005, 1284 AIDS cases were reported in the state. However, estimated number of HIV cases in Rajasthan is much higher (88560). HIV prevalence across past 7 years obtained through sentinel sites operating under RSACS has been given below;

Sites	% of HIV Prevalence						
	1999	2000	2001	2002	2003	2004	2005
STD Clinics	3.20	5.79	4.17	5.48	5.10	3.48	5.23
ANC clinic	0.25	0.33	0.13	0.72	0.17	0.24	0.45
TI project CSW					5.0	2.3	3.69
Blood bank	0.53	0.07	0.15	0.14	0.11	0.17	0.11(till Aug)
PPTCT						0.38	0.67(till July)
VCTC					18.09	15.48	13.34

Rajasthan falls under low prevalence category because the HIV prevalence rate is less than 5 percent in high-risk groups and less than 1 percent among ANC women. No definite trend across the years could be seen from any of the sources. However, in 2005 in comparison to 2004, the prevalence has increased though not significantly according to the data received from all the above-mentioned sites except Blood bank and VCTC. The prevalence recorded at VCTC is higher because majority of cases visiting VCTC include STI suspected cases and STI specialist or gynecologists refer such cases. Rest who visit voluntarily suspect themselves having STI/HIV.

VCTC visited at Dungarpur is housed in the district hospital. A team of councilors (one male and one female) reported that the prevalence rate in year 2004-05 was 14.4% (97 registered and 14 were positive) and the rate is slightly higher (16.8% - 161 registered and 27 positive) in the current year (till Nov 2005). The number of male HIV case was more than that of females (21 Male and 6 females). No data on prevalence for tribal population has been maintained at VCTC.

Vulnerable populations and causes of vulnerability

There are many factors that drive HIV. Some of these important factors include presence of high-risk groups (FSW, MSM and IDU), their frequency of sexual interaction with bridge population groups, presence of these population groups, their frequency of sexual interaction with other general population groups. Many studies indicated links of HIV with poverty, gender differences, marginalization of certain population groups, migration, extent of youth population etc. Rajasthan is reported to have potential HIV drivers like;

• High risk core groups. According to available mapping information there are 17640 CSWs, 1052 MSM and 387 IDUs in Rajasthan but the SACS officials reported that this number is under estimated because the mapping exercise undertaken in the state is incomplete in terms of coverage. The exercise covers only some districts and within a district, it covered only urban areas. In the modern times an increasing numbers of female sex workers live in the hamlets located along the highways are visible in the rural and tribal areas of Rajasthan. These women practice heterosexual activities with multipartners including the unsafe sex desired by many clients. Their clients are truck drivers, laborers, in-migrants, blue-collar workers and even armed forces personnel.

They are unable to avail infrastructure facilities like those related to health, education and development schemes either due to factors such as nomadic life, difficult access etc. In certain cases there is social stigma attached to the communities which practice commercial sex as their traditional occupation. Being illiterate and alien to mainstream, rural female sex workers are highly prone to infection and spread the HIV virus rapidly in the society through the male clients and vice –versa. Poverty, frequent droughts promoting migration to urban areas within and out-of- the state, low level of female literacy and status of women, non- availability and resistance to seek STI treatment etc. are some of the reasons which are contributing to the spread of HIV in Rajasthan[108].

• Bridge groups: Clients to sex workers constitute a bridge between high-risk population and general population. Migrants, truckers and youth groups are reported to have sexual interactions with commercial sex workers. In Rajasthan, there are high in/out migration, high truck traffic (due to mines), and high population of youth (40%). Migrants had been much talked about vulnerable group in the State. RSACS has plans to tie up with other states where these migrants migrate. They are planning to establish migration support centres at origin and destination states through which exchange of information on HIV awareness, counseling on testing facilities etc would take place. Migrants in Rajasthan include industrial workers, miners and casual laborers.

• Other vulnerable groups: Other vulnerable groups identified in the state include **street children, eunuchs, drop out children, women especially the tribal women, spouses of migrants, tourists, the daughters of sex workers,** etc. The state level consultation groups that comprise of social scientists, NGOs, technical support group, individual working on HIV/AIDS have been the source of information on vulnerable groups. Information on the same has also been derived from secondary sources by SACS officials. Where as at district level, VCTC counselor reported that the **jeep drivers** carrying passengers from villages close to district HQ are also one amongst such groups. During consultations with district level officials, the sexual involvement of tribal women with truckers and jeep drivers was reiterated.

Already, 4 TI programmes are being implemented for street children across three districts. School children have already been covered under School AIDS Education programme but out of school and drop out children would be the focus of intervention in subsequent years. Reaching out of school children who are a part of unorganized and informal labour force is a challenge. Women in Rajasthan is considered vulnerable because mostly they are not involved in decision making about their health, they tend to marry at early age, lack of awareness about AIDS among women in general and among tribal women in particular. According to district level officials, though STI cases are reducing among patients visiting district hospital but that cannot be understood as the reduced vulnerability of tribal population because the reduced number of cases could be due to the availability of more number of treatment outlets. According to them, there are many private practitioners who are more accessible to tribal people. Unstructured marriage system, loose sexual relationship, premarital sex and lack of awareness about health care decisions might be making tribal people more vulnerable to HIV. Moreover tribals have their own indigenous practices of treating STIs.

No interventions have yet been started among tribal people specifically. However, one TI programme for CSW is being implemented by an NGO (Vaghad Vikas Sansthan) in Dungarpur that partially covers these tribal women who are involved in selling sex largely to truckers on the national highway stretch starting from Udhamvilla to Kherwada. Census data indicates that Rajasthan has one of the largest concentrations of scheduled tribes in the country. At the district level Banswara (72.27%), Dungarpur (65.14%), Udaipur (47.86%) and Dausa (26.82%) districts have a high proportion of scheduled tribe population. This essentially calls for the tribal specific interventions. The tribal people particularly women are more vulnerable to HIV/AIDS due to various factors like low literacy level, limited access to health services, migration and related exploitation issues and other socio-cultural practices like NATA system wherein

• [108] Rajasthan state PIP for NACP-III, ORG Report (1995): Migratory Populations of Western Rajasthan

a person can have more than one spouses. SACS officials reported that the specific data will be available only after the precise mapping exercise and tribal interventions may be started with tribal concentrated districts. The discussion with state officials revealed that there has been a heavy influx of tourists in various cities of state. Tourists are reported to have sexual involvement with male and female sex workers. Tourists are also involved in drug trafficking.

Analysis of NGOs working in the state by area of intervention and target groups

There are in all 19 RSACS's partner NGOs that are reported to be working on HIV/ AIDS in the state. About 15 of them are implementing 16 TIs projects targeting 5 population groups including truckers, CSWs, MSMs, migrants, street children across 12 districts of Rajasthan (4 in Jaipur, 2 in Bharatpur and one in each of the 6 districts). One of these NGOs, Vagad Vikas Sansthan is implementing TI projects among migrants, sex workers and CSW in the tribal dominated districts of Banswara and Dungarpur. Of the 15 NGOS, 6 have been working since 2000-03 and 9 have initiated interventions in June 2005. The interventions basically concentrate on behavior change communication, condom distribution; provide referral services, enabling environment, etc.The state has two positive people networks one in Jaipur and one in Bharatpur. Their job is networking, advocacy and capacity building. Bharatpur positive people network has been set up recently and it caters to the needs of tribal people to some extent.

Existing PDTC Services

Prevention: The State has organized 7 Family health awareness campaigns to control the spread of RTI/STI and HIV/AIDS with effective inter-sectoral co-ordination of departments like sports, Women & Child Development, ICDS, Family Welfare, Panchayati Raj etc. Under School AIDS Education Programme, 584 schools of 24 districts were given information about HIV/AIDS. With regard to IEC interventions, various activities have been organized towards generating awareness of HIV/AIDS. The major activities included bringing awareness through radio and TV spots, cultural programmes, folk media, red ribbon caravan (rally) and camps in rural areas, etc. Red Ribbon Caravan was launched to raise awareness about RTI/STI and HIV/AIDS among general masses in rural areas to promote integrated IEC activities. This car van covered 32 districts, 241 blocks and 1200 villages of the state in 5 different circuits. The mobile vans equipped with IEC material. The counsellors, lab technicians and cultural groups also accompanied the caravan. The entire state was segmented into 5 routes and the route 3 covered Dungarpur district among other districts.

IEC materials like Hoardings, Posters etc are being presented at the public places like Railway station, Bus-stand and hospitals. IEC material collected from SACS was analysed in terms of type of messages being attempted through these material. The material messaged on definition of STI (*Yon rog*), modes of transmission of HIV/AIDS, misconceptions by messaging on modes through which HIV does not spread, modes of prevention of HIV, linkage between HIV and STI, attitude towards HIV/AIDS patients, cost and place of diagnosis, volunteer HIV testing at district hospital/VCTC etc. Most of the messages were in Hindi and a few in English.

On the occasion of World AIDS Day, 15 days programme named "*Pakhwara*" was organized at Dungarpur (Dec. 1-15, 2005) in co-ordination with NGO, Vagad Vikas Sansthan. Since co-incidentally the social assessment in Dungarpur was also conducted during this period, the field team got an opportunity to take down the details of activities being undertaken in *"pakhwara".* The programme aimed at generating awareness among general population awareness though meetings, procession, electronic (television) and print media (newspapers), sessions in schools and colleges, competitions, essay writings and dissemination of IEC materials. The programme also aimed at generating awareness among tribal girls by distributing IEC material and verbal discussion.

There are 17 TI projects that are being undertaken in collaboration with NGOs covering target segments like FSWs, MSM, truckers, migrants and street children. About 100 Condom Vending Machines (CVMs) are installed with an objective of all time availability of condom to general population. About 99 CVMs are installed in Jaipur region and 1 is installed in Dholpur district by Hindustan Latex Limited.

Diagnosis and treatment: The state has 36 STD clinics (one at Zanana Hospital, Jaipur and one in every district HQ hospital), 34 gynaec units of STD clinics (one in each district), 32 VCTCs (one in each district with 64 counselors, each VCTC has one male and one female counselor), 17 sentinel sites (6 ANC, 7 STD, & 4 CSW covering 14 district), 6 PPTCT sites (one in each zone), and one ART center at SMS, Jaipur. There are 67 blood banks (44 Govt. and 23

private) to provide HIV free transfusion and screening facilities for five diseases-Syphilis, malaria, HIV, Hepatitis B and C. FXB India Society runs one care and treatment centre in Jodhpur.

SACS officials reported that in 17 VCTCs peer counselors have also been provided (Dungarpur did not have any such per counselor). These peer counselors are HIV positive persons and the purpose of putting them on job is;

- to bring about the acceptability of HIV/AIDS
- to give message to the HIV positive person that "Though there is no treatment for HIV/AIDS, there are live examples of life even after HIV infection. Life does not end here, there is more life ahead"

Most of the diagnostic and treatment facilities are concentrated at district level. Under NACP-III RSACS has a plan to reach out to the sub -district level e.g. it has been proposed to scale up VCTC, STD clinics and PPTCT services up to CHC and PHC level. There are proposals on reaching out high risk and bridge group. One ART Centre is functioning in the State at Jaipur. The ART Centre of SMS Medical College, Jaipur (Rajasthan) has become operational from February 2005. But the person before putting to ART treatment needs to put on CD4 treatment and Rajasthan has only one CD 4 machine at ART centre Jaipur.

Care: There is one Community Care Center (Jeevan Jyoti) in Jaipur to provide all kinds of care and support to the people living with HIV/AIDS had been inaugurated in the Pink City on World AIDS day 2004. Till date 536 patients have got registered in the centre. Besides emotional and social support, the HIV positive persons are provided training on income generating activities. According to SACS officials this centre needs support from various NGOs working HIV/AIDS in identifying HIV positive persons. Home-based care programme will be implemented once a considerable number of HIV patients would be identified in the state. Involvement of chief ministers relief fund has been much encouraging. The fund provides concession on the expensive anti-retroviral drugs. A total sanction of Rs. 1.3crore has been contributed to meet the partial cost of such treatment for 320 poor patients and 58 patients, below poverty line. The people living with HIV/AIDS usually are the victims of several psycho-socials problems like stigma, discriminations etc. An "Anti-discrimination cell" has been established to help such HIV/ AIDS patients. But there has been a low compliance rate in terms of number of cases came for redressal in this cell mainly due to lack of awareness about the existence of cell.

Monitoring indicators and mechanism

Monitoring of programme was perceived to be very difficult at state and district level. Appointment of M & E officer is in process. Hence detailed information on M & E indicators could not be obtained. A computerized Management Information System (CMIS) is in place at state level through which reports are sent to NACO periodically. In NACP-III PIP RSACS has proposed that CMIS, integrated with the INTRANET of RSACS will be developed so that the district level inputs can be entered at district level only.

ANNEXURE 3.2: STATE PROGRAM- WEST BENGAL

RESPONSE OF SACS AND PURULIA DISTRICT OFFICIALS

The first HIV positive case in West Bengal was detected in 1986. The number of HIV infected cases in West Bengal was 304 in 1996 that grew to 371 in the year 1997. West Bengal State AIDS Prevention & Control Society (WBSAPCS) was set up in 1998 in response to these growing challenges, and on the basis of evaluation of India's NACP-I evaluation, stressed on decentralization of HIV/AIDS related planning and implementation to the state and district levels, in the context of local socio-economic conditions. WBSACS was formed according to NACO guidelines as a quasi-government body. It was set up as a registered society in Kolkata, the state capital.

Since monitoring and supervision at the district level was a key component of NACP-II, the responsibility for implementation of the programme was further decentralized to District AIDS Control Societies (DACS). Each DACS was to be lead by the Deputy Chief Medical Officer of Health – II of the district (DCMOH), and function in coordination with WBSACS. For social assessment of NACP arrangements, the discussions were held with officials of Purulia District AIDS Control Society.

HIV Prevalence

Though West Bengal has been categorized under low prevalence tier as per the median antenatal prevalence not over 1 percent and below 5.0% in the STD clinics but the state shows the presence of all common vulnerabilities & structural determinants to fuel HIV. The situation getting beyond control with HIV spreading into general population and low awareness as to HIV, testing and service packages justify the state for vulnerable category.

HIV Prevalence during the period 1999- 2005 has been presented below:

Site	% of HIV Prevalence						
	1999	2000	2001	2002	2003	2004	2005
STD Clinics	1.34	1.73	0.8	2.23	2.68	2.79	2.56
ANC clinic	0.13	0.39	0.10	0.31	0.45	0.48	0.9
TI project IDU				1.46	2.61	2.22	7.4
TI project FSW					6.46	4.11	6.8

Source[109]: WB SACS

Data indicates increasing trend for HIV prevalence in the state from all types of sentinel sites, though no linear increasing trend was observed. Among high-risk groups, in 2005, in comparison to previous years, the prevalence of HIV has increased.

In all 8148 HIV positive cases have been reported across all the districts of West Bengal in the period 1986-2005. Kolkata (2722), West Midnapur (796), 24 Paraganas-North (657), 24 Paraganas-South (635) and Darjeeling (434) have been identified as the districts where the number of HIV positive cases is much higher than other districts. In Purulia, the study district, a total of 65 HIV positive cases have been reported in the period 1986-2005.[110] At Purulia VCTC, Only about 13 (out of 336 tested since inception) cases were tested positive. A case of an entire family - husband (truck driver, died), wife and child; being HIV positive was reported. Also a CSW from the city had been tested positive and the most recent case was that of a 16 year old student who had commercial sex. No particular trend with

[109] West Bengal State AIDS Control Society : HIV/AIDS Scenario http://www.wbhealth.gov.in/wbsapcs
[110] West Bengal State AIDS Control Society : HIV/AIDS Scenario http://www.wbhealth.gov.in/wbsapcs

respect to tribal population was observed in the data or reported by the VCTC staff. It was felt that the infection was spreading more among people who are traveling or migrating for work.

Vulnerable populations and causes of vulnerability

During discussion with the WBPSU consultant and review of the secondary sources, it was found that the state has large number of population from high-risk groups like female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (IDUs). These high-risk groups are present in almost all the districts. The highly vulnerable groups identified in the state included migrant labourers and truck drivers and other vulnerable groups included **street children and brick kiln workers (women including tribal women working at the brick kiln).** Brick kiln male workers reportedly develop sexual relations with female workers, majority of these were tribal women.

The proximate cause of the vulnerability of high-risk groups is unsafe sex (FSW, MSM) or sharing and reuse of unsterilised needles (IDU). The underlying causes that make such high-risk groups vulnerable result from a complex interplay of social, economic, cultural and other systemic factors like poverty, gender differences, weak health delivery system, poor infrastructure and lack of intra-sectoral coordination. Moreover, lack of awareness makes them all the more susceptible to the infection.

Migration is also one of the major causes of the vulnerability of HIV infection. There is considerable migration both in and out in West Bengal. A significant number of people from neighboring states migrate to West Bengal particularly in urban centres of the state. At the same time, many people migrate from West Bengal to areas like Mumbai or Gujarat to find work. During discussions with the WBPSU consultant, NGOs and review of the secondary sources, it emerged that hostile and lonely environments, separation from families, lack of access to information and services and social support systems lead the migrants to sexual practices that in turn make them more susceptible to HIV exposure. Rampant gender inequalities and the inability to bargain for safer practices in sexual relationships further increase their vulnerability.

At district level, it was reported that there are no HRGs in the Purulia district. There used to be a brothel area a decade back but it is not operating now. There are only a few flying sex workers who operate near the bus stand, railway station and district hospital. Further, it was reported that there is minimal presence or near absence of IDUs or MSMs in the district.

With regard to vulnerability of tribal people, there were mixed reactions. When probed, it was mentioned that both tribal and non-tribal people are at risk and the relativity of risk was not higher in case of tribal people. The behavior in terms of sex, migration etc of tribal people reported did not indicate high risk towards HIV/AIDS. However, some believed that tribals are vulnerable because pre-marital and extramarital sexual practices and sex with multiple partners are quite rampant among them. The sexual exploitation of the tribal women at the road construction sites, brickfield sites by their contractors is also very common. This requires further exploration.

Interventions focusing on vulnerable tribal communities

During discussion with the WBPSU consultant and the review of the secondary sources, it emerged that there are 43-targeted intervention programmes being carried out in the state. These interventions have focused on behaviour change communication, diagnosis of HIV/AIDS, treatment of STD and HIV, Condom promotion, blood safety and community mobilization.

However, the discussions at WBSPU pointed out that State AIDS Control Society has not focused any of its interventions on the tribal communities. Most of the programmes carried out by the SACS have focused in the urban areas of the state and these programmes have not made any significant inroads into the tribal pockets, which are generally centred in the rural and suburb areas of the state. Discussion with the NGOs also revealed that there is no NGO in the state, which is specifically focusing its HIV/AIDS programmes on the tribal communities. However, the migrant tribal people who are living in the urban areas are covered by the ongoing intervention programmes as part of the general population or migrants.

Analysis of NGOs working in the state by area of intervention and target areas

In West Bengal, there are more than fifty NGOs, which are working in close collaboration with the State AIDS Control Society. Almost half of them are involved in the target interventions programmes. Most of them are working with the Commercial Sex Workers (CSWs) in different areas of the state. Many of the organizations are working with the migrants as part of the targeted interventions programmes. Some of the organizations are also working with the Injecting Drug Users (IDUs), Truckers, Street Children, Prison Inmates and Students. A significant number of the NGOs are involved in providing tele-counseling on HIV/AIDS to the general population. A few of the NGO are also involved in providing care and support facilities to the People Living with HIV/AIDS (PLHAs) and Blood Safety programmes.[111]

During discussions in the West Bengal Project Support Unit, the above-mentioned activities of the NGOs, which are working in the state, were confirmed. He added that there are some NGOs, which are involved in HIV/AIDS education programmes among students. He also pointed out that many of these NGOs approach WBSACS and WBPSU for support. WBPSU in turn provide them IEC materials like, posters, pamphlets, condoms, etc. In addition to it, WBPSU also gives them counseling to make them better equipped to work in the area of HIV/AIDS. Discussion with the DACS official revealed that although there is a significant number of NGOs working the study district (Purulia), none of the NGOs is working in the field of HIV/AIDS. Moreover, the work area of these NGOs is most of the time restricted to a few villages and the bigger ones among them cater to 2-3 blocks at the maximum.

In the study district of Purulia, three NGOs were identified for interaction – Kalyan (working in livelihoods for the Tribal people), Fight for Purulia (working for Thalsemia in Purulia) and Paschimbanga Kheria Sabar Kalyan Samity (working upliftment of Sabar tribe). But none of these organisations are focusing their activities in the area of HIV/AIDS. Though some of them are interested, they would need direction and support to initiate activities in the areas of HIV/AIDS. Some NGOs, however, do collaborate with the DCMOH to organize meetings, distribute posters and organize rallies etc. There is lack of continued effort in this regard.

Existing PDTC Services

Prevention: While the State AIDS Control Society has 43 Targeted Interventions for HRG namely Commercial Sex Workers, Injecting Drug Users, Men Having Sex with Men and other bridge population like Truck Drivers and Migrant Labour at different sites all across the state, the Information, Education and Communication for the general population was still a neglected dimension till now owing to the tremendous budgetary constraint for the same. With the epidemic making its inroads in the general populace, WBSAPCS is responding to the changing face of the epidemic.

Apart from the conventional mass media viz. outdoor, television and radio, attempt is being made to leverage unconventional ones as well, increasing the touch points manifold. The Call for Action for Phase I of Bula Di Campaign was essentially that of getting people in need of information on the issue to call up 1097 and that for Phase II being that of getting people to go for HIV testing. The message on consistent and correct use of condom remains common to both the phases and has been particularly highlighted for the initiatives that reach out to the transport and hotel and lodge industries. The campaign was launched in phases. In the ***Phase II*** of the Bula Di Campaign, key focus areas were to reach out to the *Transport Sector, Chemist Shops, Hotel and Lodge based interventions, Liquor Shop Owners,* with the continuation and further up-scaling of the campaign.

School AIDS Education Programme was initiated and pioneered by the UNICEF, however, it was later covered under NACP II. Now, SAEP is a major component of the awareness campaign carried out by West Bengal State Control Society. Now SAEP programme is being carried out in several districts of the state with the support of the NGOs.

Diagnosis and treatment: VCTC services have been expanded rapidly in the state. In all, 22 VCTCs including one community based VCTC are functioning in the state. The latter is an integrated VCTC run by an NGO CINI, which provides family welfare services to women in rural South 24 Parganas. However, the performance of the VCTs has not been up to the expectations and the attendance in these centers has been low. Some potential reasons could be low awareness among the general population about the VCT services, stigma and discrimination against the HIV positive people, low prevalence of risk behaviour among the general community, no perceived benefit of doing the tests. In

[111] NACO (2003), Directory of Services, State wise list of NGOs –West Bengal (http://www.nacoonline.org/ngo-list/wb.pdf)

addition to the private STD clinics, there are 34 STD clinics funded by NACO and 23 clinics funded by State Government in West Bengal.

The state has made major progress in the area of blood safety in recent years. Currently every unit of blood in the State is being screened for Malaria Parasite, hepatitis B and C, VDRL and HIV. Commercial blood donation has been totally phased out in the state. There has been a steady increase in the number of voluntary blood donors over the years and West Bengal is one of the best performing states in this regard. There are 59 blood banks attached to the government health facilities across the state. In addition to it, there are 38 private blood banks approved by the State AIDS Control Society. One major plus point felt by one NGO in Purulia was that there were no private blood banks in the district; there was only one at the district hospital. The standard of blood testing at the Blood bank was high thus there were almost nil chances of the spread of virus through blood transfusion.

Care and Support: The number of people and families living with HIV/AIDS in West Bengal is continuously increasing thereby increasing the demand for care and support at institutional, community, and family levels. One of the main problems being faced by them is stigma and discrimination in society and in health care institutions that prevented them from acknowledging their status. To a great extent the discrimination faced in health care institutions were addressed through special sensitization programmes in hospitals for the medical staff. Efforts were made to mainstream HIV/AIDS into the medical education, training programmes and so on.

To ensure effective implementation of Greater Involvement of GIPA principles, PLWHA members were included in all decision-making or other prominent forums and bodies - Executive Committee, Ethical Committee. In the year 2004, the *Bengal Network of People Living with HIV (BNP Plus)* was formed encompassing all different network of PLHA. To start with, the network registered a membership of 1200 members covering the Kolkata Network of Positives, Enjoy – Howrah and Kolkata, CINI-Bandhan and Bhoruka – Bhalobasha. The presence of a united front of positives would not only ensure the emergence of the Positive group as a much stronger pressure group but shall also ensure meaningful fund flow and utilization. The GIPA component was looked at through the Targeted Interventions also with an essential component of PLWHA support in each of the project.

The activities on Care and Support were carried out through Bhoruka -Bhalo Basha, Home based C&S Centre, SPARSHA and KNP Positive networks. Bhalobasha intended to initiate a vocational training centre for the Positive women, institutionalizing of HIV orphans and impending orphans through sponsorship or collaboration with other funding bodies. Kolkata Network of Positives strengthened its base and reaches to the districts and Kolkata over the last one year and also formed a very prominent role in the setting up of the BNP Plus. PLWHAs were more actively involved in all the sensitization programmes. They had addressed the press and electronic media to raise awareness about the issues among the general public. For income generation activities, a pilot initiative in forming a SHG in Bankura took off.

Currently there is only one Government ART Centre in the state. It is located in School of Tropical Medicine, Kolkata. About 1000 PLWHA are receiving ART in government institutions in West Bengal. In addition, ART is also being provided by the private sector. Government is committed to providing ART to those who need it most. NACP-III will scale up this service to a larger number of people through effective public-private partnership and community participation, while at the same time ensuring compliance and drug adherence. To increase the number of eligible PLWHA on ART, VCT will be promoted. Persons will be referred to the VCTC from general hospitals, TI - NGOs.[112]

Monitoring indicators and mechanism

Discussion with the WBPSU revealed that SACS follows some monitoring indicators such as behavioral changes in the community, STI management level, condom consumption, enabling environment etc. Continuous process level monitoring is also carried out using CMIS on the following components: blood safety, TIs and Care and support programmes, STI treatment, VCT, IEC, AIDS surveillance, PPTCT. As reported by the DACS official, there is no monitoring mechanism to assess the impact of its efforts in containing the spread of HIV/AIDS in the entire district including tribal pockets.

[112] West Bengal State NACP-III PIP Document 2005

ANNEXURE 3.3: STATE PROGRAM- CHHATTISGARH

RESPONSE OF SACS AND RAIPUR DISTRICT OFFICIALS

HIV Prevalence:

With respect to HIV/AIDS cases, the Chattisgarh state falls in a low priority zone. The tests for HIV/AIDS have been initiated in the year 2002. The cumulative figure of HIV/AIDS from 2002 to till date (up to October 2005) is 713 for HIV positive cases. The information on HIV prevalence rates was not available. The following figure obtained for Blood bank and VCTC depicts the number of HIV positive cases in past three years.

Sites	2002	2003	2004	2005	TOTAL
Blood Bank	52	51	81	65	249
VCTC	-	37	187	240	464

Vulnerable populations and causes of vulnerability

As per the guidelines of NACO, the mapping process was carried out by the NGOs in the state through CGSAC. The high-risk core transmitter group encompassed female sex workers and the highly vulnerable group, the truckers and migrant labourers (industrial and factory workers). The discussions with state and district officials revealed that generally high-risk behaviour activity is found in the urban and industrial areas of the state. The tribals are not involved in such activities as they lead life with the activities like visiting forest areas to collect food items, craft materials, mahua flowers etc. *"ye santoshi jiv hai. Voh bus apna forest resources se gujar basar kar lete hai. Unko thodi materialistic things chahiye. Unko to bus jungle me se khana mil gaya, mahua mil gaya to pina ho gaya"* As per the social infrastructure action plan of the Chattisgarh state, male worker participation rate is higher than female as male illiteracy is very high. Hence, female are engaged in paddy cultivation. Further, farm (agriculture) sector dominates employment. About 82 % of all workers and 90 % of all rural workers are involved in farm (agriculture) related activities Due to industrialization, the highest per capita income is high in the districts of Durg and Korba and per capita income of male is twice than that of female PCI. This supports the observation of NGOs, SAC and DAC officials that high-risk behaviour is found in industrial areas and the common mode of transmission among female spouse is through male counterpart.

Analysis of NGOs working in the state by area of intervention and target areas

In all, 17 NGOs were functioning in the state on NACO based projects. Two of these 17 NGOs were functioning in Raipur district. All the NGOs have focused their activities on CSW, migrants and truckers in the state. The state Tribal Research Board reported that a total of 39 NGOs are working for the tribals but only in the education sector. An IDI with CMHO and NGOs showed that under CARE funded "Chayan" programme wall writings on HIV/AIDS issues have been carried out in urban, rural and tribal areas of the state. A total of 17 interventions are carried out in the state. On the basis of information collected from SAC and DAC officials, discussions with CHC, VCTC and NGO staff, the interventions can be categorized as providing the following facilities: Diagnostic facilities, STI treatment facilities through government and NGO set up, IEC which covered entire state population. Till date, no specific interventions addressing tribal people are ongoing.

Existing PDTC Services

At present, CGSAC has 9 blood banks, 16 each STD clinics and VCTCs (one each in the district), 12 sentinel sites and two PPTCT centers in the medical colleges of Raipur and Bilaspur. One ART center at Pt Jawaharlal Nehru Medical college, Raipur and community care center at Bilaspur are being established. In addition, a facility of the toll free number (1097) for HIV/AIDS awareness and counseling is also provided. Efforts to establish people living with HIV/AIDS (PLWHA) network are under way. About 80 HIV positive persons have been contacted and they have agreed to join PLWHA network. Apart from this, CARE has funded IEC component of HIV/AIDS to NGOs. The NGOs carry out various IEC activities such as wall writing, group education sessions etc.

Monitoring mechanism

Monitoring and evaluation officer as per guidelines of NACO undertakes monitoring activities. A discussion with monitoring officer and evaluation showed that formats designed by NACO are utilized and through web network are sent to them. The monthly reports from the districts and NGO are received in hard copies. A web linkage with the districts is proposed in the PIP – III.

ANNEXURE 3.4: STATE PROGRAM- MAHARASHTRA

RESPONSE OF SACS AND THANE DISTRICT OFFICIALS

***HIV Prevalence*:**

As documented by MSACS, the high rate of migrating and floating population, coupled with the well established sex industry has triggered the situation of HIV prevalence in the state. Maharashtra is cited as high prevalence state because HIV prevalence rates exceed 5 percent among high-risk groups and exceed 1 percent among antenatal women. HIV prevalence in antenatal clinic is 0.75% and in STD clinics is 10% as in 2004. There are 1, 22,314 registered HIV positive persons in the state today and an estimated figure of 10, 00,000 people living with HIV / AIDS. The total number of AIDS Cases is 20,318 and those who have died are 1821.

HIV prevalence in Maharashtra (2004) (Draft PIP, MSACS)

Data Source	HIV prevalence rates
All ANC Sentinel sites in Maharashtra	1.00
ANC Sentinel sites- All urban	1.25
ANC Sentinel sites- All rural	0.50
STI Sentinel sites – Outside Mumbai	10.4
Blood Donors (Blood banks) – Outside Mumbai	0.70
BTCs, VCTCs & PPTCT data – Outside Mumbai	11.5

In Thane, the study district, a total of 1008 HIV positive cases have been reported, of which 27 percent are women[113]. Prevalence data pertaining to the different districts was not available. According to the Incharge, Thane DACS, Diagnosis has not taken place in tribal areas so far due to the absence of VCTCs in the tribal belt.

Vulnerable population and causes of vulnerability

Core groups at high risk of contracting the infection identified in the state include FSW, MSM and IDUs. There are groups that are highly vulnerable like hijras/ eunuchs, truckers, migrant workers and street children. The other vulnerable groups include youth and orphans. In Thane, three major population groups emerged who could be at high risk of getting infected. These included migrating population, including the ones serving in defence, truckers passing along the highway and general tribal people – men and women. One of the examples sited by the DACS official with regard to the general population was – the women soliciting sex work in the garb of selling dry fruits on the lonely stretches of highways. The discussions with locals and people who have previously worked in tribal areas revealed that there were stray incidences of young girls getting involved in sex trade with truckers to make a quick buck and under peer pressure. The visibly good lifestyle of girls involved in the profession instigates more girls to get involved in the process.

In the tribal areas, the perceived major cause of vulnerability by district level officials and NGOs was gauged as migrating nature of the population. People who migrate during the dry season may or may not stay away from home for long periods. Even in such cases when the individual commutes to and from work on a daily basis, s/he is likely to get involved in risky sexual behaviour at the work place. Quite a few villagers migrate to neighboring areas in search of work during the dry season when there is no agricultural yield. Some of them also go to different places on a daily basis. They mainly migrate to areas of outer Mumbai and Thane like Palghar, Bhivandi, Vasai, Virar and Bhayender to work in Salt pans or construction industry. The industrial belt of Vapi, Silvassa and Dadra & Nagar Haveli also attract a number of locals to work in factories producing variety of small and big products. The ones who live away for longer periods usually come to their home towns during festivals like Holi and Diwali. Getting involved in risky behaviour during such visits is not unusual.

[113] Maharashtra SACS Statistics (2005) AIDS Case Surveillance Report http://www.msacs-india.com/statistics.html

Analysis of NGOs working in the state by area of intervention and target groups

Various NGOs are associated with MSACS in delivering messages and awareness on HIV/AIDS to the masses. Latest list of MSACS partner NGOs was not available. According to previous year's list of NGO (2004), a total of 31 NGOs have been working on HIV/AIDS in Maharashtra - 9 with CSWs, 10 with truckers, 4 with migrant workers, 3 with PLHA and 1 each with street children, street girls, students, MSMs, IDUs and Eunuchs. Out of 31 NGOs, 17 have been working in Mumbai only and 1-3 NGOs in remaining districts. About 53 NGOs are associated with Avert. Five of them work with Commercial Sex Workers, 3 with truckers, 2 with MSMs, 1 each with trans-gender and prisoners, 4 with migrant workers, 9 in slum areas - composite groups, 13 in the area of work place interventions and as many as 15 NGOs in the area of care and support of persons living with HIV/AIDS. MSACS officials reported that there were 4 NGOs working in the area of HIV/AIDS in Thane district- Uddan, SAATHII, Nagari Seva Prabhodini and Rashtra Swasthya Prabhodini. Inspite of 4 NGOs being operational/ active in the district, interventions have not reached tribal areas. Some of the tribal population may be covered under different programmes run by NGOs in other parts of the state and country where they migrate for work, but not in their own village/ area.

Existing PDTC services

Prevention: IEC is one of the most important and imperative part of prevention of HIV/AIDS. A number of activities have been conducted by MSACS with the help of NGOs and other organizations to spread the message on prevention of HIV/AIDS. Folders containing information on PPTCT and VCTC have been in circulation. Hoardings displaying messages against stigma and discrimination against PLWAs have been displayed across all districts in the state, efforts have also been made to put up hoardings at district hospitals. Posters have been designed and developed on issues like blood safety, stigma and discrimination, VCTC and PPTCT. These are distributed to PHCs, DHO, CS, Rural hospitals, Medical Colleges and NGOs as well as sub-district centres. The quarterly magazine of MSACS provides updated information about HIV/AIDS and MSACS activities to Doctors, NGOs, CBOs, Primary Health Centres, Medical Colleges, MLAs, MPs, Collectors, Commissioners and CEOs.

School Adolescence Life Skills Education Programme (SALSEP) provides health education to adolescents through schools. Through the Family health awareness campaigns (FHAC), the target population aged (15 to 49 years) is sensitized towards sexually transmitted diseases. All efforts are made to encourage early detection and prompt treatment of RTI/STD by fully involving the community and to make the people aware about the services available in the Public Health System for the management of RTI/STD. Thus, various interventions and preventive measures have taken place in the state and the district. As stated earlier, interventions have not reached tribal populations as they should have. Marriage and sociological structures still remain the same, which make them all the more vulnerable to the infection. For the tribals to understand and take prevention measures, it is important that the messages reach them in the first place.

Diagnosis In Maharashtra, all over the state, 34 STI clinics are operational. The total number of VCTCs/ ARVs and PPTCT centres are upto 50 in number. The draft PIP mentions the need for regulation of private labs carrying out HIV testing so that they follow the same protocols as followed in the Public Health Systems. This procedure needs to be applied wherever HIV testing is happening, like nursing homes, private labs and large hospitals. VCT and PPTCT services need to be upgraded to capture the entire infected population. There are four VCTCs operational in Thane District. However, only one VCTC was operational in the tribal areas and it had opened recently in the Rural Hospital of Jawhar. The VCTC had appointed a counselor. The counselor had not received training yet.

Treatment and Care:

In the entire state of Maharashtra, in all, 12 centres have been established to provide Anti Retroviral Treatment (ART). Of these, 4 are in Mumbai while the remaining 8 are located in other parts of Maharashtra (none in Thane). In case of care for PLHAs, Community Care Centre was established in Panchgani, District Satara, at Bel Air hospital in 2000. Further, 6 more care centres and 5 drop in centres were established, none in Thane.

ANNEXURE 3.5: STATE PROGRAM- MANIPUR

RESPONSE OF SACS AND CHURACHANDPUR DISTRICT OFFICIALS

As per UNAIDS estimates, out of 4.2 crore people living with HIV/AIDS in the world, around 5.1 lakh people are in India. Manipur constitutes 0.21 % country's population but accounts for nearly 8 % of the total HIV positive cases.

HIV Prevalence:

The first case of HIV positive in Manipur was identified in 1990 among the IDUs. HIV Positive cases up to March 2002 were estimated at 13,184 (Male 11426 and female 1758). About 1151 cases have resulted in AIDS with 203 deaths by 2002. In 2004, out of 19204 sero positive cases, 18 % are females and 3327 cases have resulted in AIDS with 469 deaths till date. The following figures show prevalence from various sentinel sites:

Risk Group	1998 (Feb-March)	1998 (Aug-Sep)	1999 (Aug-Oct.)	2000 (Aug-Oct.)	2001(10th Aug –15th Nov.)	2002(Aug-Oct.)	2003 (Aug-Oct.)	2004 (July-Sep)
IDUs Pre.	67.63	72.78	55.48	66.02	56.27	39.57	30.7	21
Preg Women Prev.	1.18	1.69	2.70	1.07	2.04	2.4	1.34	1.66
STD prev.	4.48	5.79	10.00	11.76	10.00	9.6	13	7.2

It is one of the sixth high prevalence states in India because prevalence rate among the pregnant mothers attending ANC remained more than 1% and at STD clinic more than 5 percent in past 7 years (refer table). The prevalence among IDU was very high. The precarious scenario induced the state government to execute State AIDS Policy on October 3, 1996. The implementation of Rapid Interventions and Care (RIAC) have yielded encouraging trend, bringing down sero-prevalence rate from 72.78 in 1998 to 21% in 2004 which is still highest in the world. Now the infection has spread to their sexual partners and their children. In the assessment district, the HIV prevalence was 7.3%. However, the prevalence separately for tribals has not been worked out.

Vulnerable populations and causes of vulnerability

Manipur is geographically close to the "Golden Triangle" where more than 20 % of world's heroin drug is reportedly produced. Due to perforated borders, the state has become alternative route for illegal drug trafficking and by early eighties it became the user state. The mapping exercise has revealed that along with Injecting drug users (IDUs), the other high risk groups identified in the state were CSWs, and MSM. During state level consultations with SACS and DACS officials, NGOs it was reported that the group of highly vulnerable populations included STD patients, TB patients, truckers and migrant workers. The other vulnerable groups include defence personnel and the spouses of core HRGs, i.e. spouses (regular sexual partners) of IDUs, CSWs and MSMs. From wives of HRGs the vertical transmission occurs, posing a great threat to the future generation. Consequently, the prevalence among pregnant women is on rise – 0.8 % in 1994 to 1.34 % in 2004. HIV prevalence rate among TB patients has also increased from 3.31 % in 1994 to 18.75 % in 2004.

Analysis of NGOs working in the state by area of intervention and target areas

As on March, 2005, there are 62 NGOs implementing 69 projects in the state, covering tribal area. 45 NGOs are implementing rapid intervention and care projects, 5 NGOs working with FSWs, 6 with community care centres, 4 with drop in centre and the rest few are working with Healthy highway project, tele-counseling and MSM projects. In the study district, three NGOs were reported to be working in the area of HIV/AIDS. The Mahila Vikas Samiti, Khongman Okram Chuthek Makha ran RIAC for IDUs and Society for HIV/AIDS and Lifeline Operation in Manipur SHALOM group had community care centre while Progressive People Organization (PPO) and Singjamei Mathak worked with CSWs. In study villages, PPO works on STI awareness issues.

Existing PDTC Services

Manipur SACS has six components under its HIV/AIDS programme which takes care of prevention, diagnosis, treatment and care services for HIV/AIDS.

I. Prevention:

To promote preventive activities for control of HIV/AIDS, MACS has performed various IEC activities. Under IEC portfolio, the various activities included were;

- Observation of worlds AIDS day by state, district and panchayati functionaries
- Workshops, training/awareness programmes/ exhibitions for community leaders, media and general public
- Capacity building: 100 persons from various media, 3000 youth and students, 3000 community, 2400 political, 1200 religious leaders were trained in a 3 day workshop
- Directorate of Advertising and Visual publicity organized health exhibition
- A state level poster competition in collaboration with Indian Red cross society
- 250 radio spots, 3 episodes of TV quiz
- A five residential national integration cum youth leadership for 200 youths
- One day awareness for 500 casual labourers
- 50 participants of Miss Manipur Beauty contest given training on HIV/AIDS
- 250 folk plays

Tele counseling centre: The purpose of tele counseling centre is to provide correct information regarding preventive, diagnostic, care–support and treatment services for HIV/AIDS and to eradicate myths–misconception about HIV/AIDS. In all 1815 valid calls have been attended since its inception in April 2003.

School AIDS programme: About 700 each peers and teachers across 350 schools were trained. The study team observed that this programme has effectively reached out to rural areas**.**

II. Diagnostic

MSACS has established 22 VCTCs including one CBO and 6 CCCs across nine districts in the state. In the past two years, 12408 samples have been tested and 3544 (28.6%) are found sero positive. About 12964 persons have been counseled during this period. Ten STD clinics across nine districts are functioning in the state. The past year's data showed that STIs are high among women than men. The HIV prevalence STD sentinel surveillance is 7.2 %. In addition, 10 PPTCT programmes are ongoing in the state. During 2004, 20163 ANCs were registered and only 2621 (13.0 %) undertook HIV test and 0.6 % were found sero positive. There are two major blood licensed banks namely Regional Institute of Medical Sciences and J N Hospital, 7 district blood banks and one blood components separation unit. In addition, there is one more licensed blood bank at DHQ of Churachandpur. From 1995 till date, 97318 blood units have been collected through 3 licensed blood banks and almost were tested for HIV. Only 1.46 % (1423) were found sero positive.

III. Treatment, Care and Support

Under 65 RIAC projects in the state, 11092 clients have been given care services. About 2992 CSWs and 1249 migrants with STI have been rendered treatment services. Under low cost AIDS care, 6 community care centres (CCC) are in operation in the state. Of these 6 CCCs, one is located at district head quarter of the study district. A total of 3634 PLWHA have been registered from its inception in May 1999 till date. Of these, 67.6 % were admitted and fatality rate was 17.7 %. Apart from this, two drop in centres for PLWHA have been established in two districts Imphal west and Thoubal. At present, two ART centres are functioning in the state. Both are located in the state capital. The one located at RIMS has provision of 300 patients and the other one located at J N hospital has 200. In the past two years, 423 patients have availed the services.

ANNEXURE 3.6: STATE PROGRAM- ANDHRA PRADESH

***HIV Prevalence*:**

As per UNAIDS estimates, out of 4.2 crore people living with HIV/AIDS in the world, around 5.1 lakh people are in India, and above 5 lakh people are in Andhra Pradesh. In 2004, the prevalence rate from ANC sites in the state was recorded as 2.25 as against 1.25 in 2002. The data received from Visakhapatnam DACS says that out of 11,122 people who have visited VCTC of this district in the year 2004 – 2005, 18.7% (2081) found to be HIV positive. 1.70% (296) of the pregnant women who had visited ANCs had found to be positive in the year 2004 – 2005.

Vulnerable populations and causes of vulnerability

The high risk groups at state level included commercial Sex workers and MSMs. Truckers, Street children, Prison inmates, Slums dwellers, Transgender and migrants were other vulnerable groups reported by state level officials. It also had been stated that the vulnerability was more where there is tourism is developing. Hence, the vulnerable groups comprise tourists also. In Visakhapatnam district, according to DLO, apart from high-risk group of CSWs, migrants were considered as the most vulnerable group. The people coming from various mandals of the district to the district headquarters for labour and other jobs were reportedly getting involved in multiple partner sex during their stay and by doing so spreading the infection to their family and the community. The other vulnerable groups of the sample district were truckers & drivers, slum dwellers and street children. As reported by DLO, NGO and secondary sources, in tribal area, Shandy vendors and Dimsa Dance troops were also considered as vulnerable groups**.** Shandy vendors are the people (Tribal) who come to sell their products in weekly market. Mostly the women folk from these tribal communities come to sell the products rather than men in the weekly market. During these Shandy days buyers come from the plains, mostly the middlemen, negotiate with the vendors of their choice and solicit sex. Some times the vendors solicit sex and some times they simply get attracted to the people coming from the plains and develop relationship for dun. Dimsa is a traditional tribal dance performed by a group of tribal women in response to the music played by the male folk. To develop tourism and attract tourists in Araku valley this dance is organized in AP tourism house and other hotels of Araku valley during the night. The visitors (tourists) are also allowed to dance along with them (male & female), which is also acceptable in their community. After the programme tourists who would like to seek sex are allowed to negotiate with the tribal women. In earlier days Dimsa dancers solicited sex with the tourists for fun, but in the course of time, started selling sex. This has made the programme managers consider them as one of the vulnerable groups.

Presence of NGOs

AP Government is promoting sexual health among high-risk populations through implementation of 108 targeted interventions, out of which 83 targeted interventions are implemented by NGOs. Details of the project comprise Sex workers (20), Truckers (22), Street children (6), Work Place Interventions (4), Prison interventions (25), Slums (17), Composite intervention (11), MSM (2) and Transgender (1). In Visakhapatnam, five NGOs have been identified by APSACS to take up programme for high-risk group (MVS: slum intervention, PSO: Sex workers intervention, SEED: Street Children, ACCEPT: Truckers Intervention and NATURE: slums and migrant population). Apart from this, other NGOs like PSI, World vision, Green Vision and FXB is also working in the AIDS control and prevention programmes. NATURE is the only organization working in Visakhapatnam for the tribal people focusing HIV/ AIDS. They have been sanctioned grants to implement TIs among CSWs and Migrant workers in Anathagiri and Araku mandal. The TI for Migrant workers also covers drivers and helpers of the vehicles operating in those areas and shandy vendours.

Existing PDTC Services

APSACS is promoting sexual health among high-risk populations through implementation of 108-targeted interventions. Each of the Projects have four components i.e. BCC, STD Care, Condom Promotion, creation of enabling environment by taking up advocacy and by establishing linkages with law enforcing agencies. About 10-lakh high risk population is covered through targeted interventions. Bill & Melinda Gates Foundation has taken up 60 projects for saturated coverage of sex workers and truckers for prevention and control of HIV among the high-risk groups. These are implemented by the foundation lead partners HLFPPT (Hindustan Latex Family Planning Promotion Trust) and International HIV/AIDS Alliance. In order to prevent vertical transmission of HIV from mother to child, 41 PPTCTs were setup in 14 teaching and 23 district hospitals. New 56 PPTCTs are being established in covering all

area hospitals in order to provide services in rural areas also. In the sample district five NGOs mentioned in the earlier section had taken up the task of implementing the programme for the High-risk groups.

IEC activities: Activities taken up under Total Awareness Campaign from February'05 to July'05:

- Campaign through Folk and Street theatre medium was taken up in nine high prevalent districts in February'05 in coordination with Song and Drama Division and reached an audience 1, 56,837.
- State level media consultation was organized with the support of UNICEF and AP Press Academy to sensitize State level media on HIV/AIDS.
- Intensive programme campaign was taken up on the Electronic Media including Doordarshan and All India Radio from February'05 to May'05.
- A village AIDS Awareness Club was formed in 28 villages of Yerrupalem mandal, Khammam district. The replica of this model would be adopted all over the State with NSS volunteers and youth club members.
- Under mainstreaming of HIV/AIDS, a programme to reach 17,00,000 rural population in 2,600 villages in 19 districts is taken up in Febraury'05 in coordination with Centre for World Solidarity.
- A total number of 1, 57,275 people were reached through interpersonal communication through the 'AIDS Walk for Life' organized in nine coastal districts jointly by Project Concern International (PCI) and AP State AIDS Control Society.

AASHA (AIDS Awareness & Sustained Holistic Action), an intensive campaign with an integrated and comprehensive partnership approach involving stake holders at different levels was conducted for one month during July'05.

- AASHA was taken up with a twin objective of 100% awareness generation and strengthening service delivery.
- Special Gram Sabhas on HIV/AIDS were held in 34,106 villages through which 1,12,78,344 population could be reached with messages of HIV/AIDS.
- Intensive half an hour programme and Ad campaign was taken up for the whole month on popular television channels and All India Radio.
- 9272 folk performances in coordination with rural development department were organized during July'05 with a special focus on tribal areas.
- Competitions on HIV/AIDS were held for school and college students all over the State.
- Partnership Forum to fight HIV/AIDS was launched.
- Advocacy and trainings with Print and Electronic Media Journalists were organized in coordination with UNICEF, Centre for Advocacy and Research (CFAR).
- Short film on HIV/AIDS was screened in all the theatres in the State.
- 1200 trained people living with HIV/AIDS (PLHAs) participated in the campaign.
- 100 more voluntary Counseling and Testing Centres (VCTCs) and 56 more Prevention of Parent to Child Transmission (PPTCTs) centres were opened during July'05.
- 1, 73,135 cases were referred to the services like VCTCs, PPTCTs, STD clinics and ART Centres.

Other state level activities under IEC Component are Electronic Media campaign, School AIDS Education Programme, Colleges Talk AIDS Programme, HIV/AIDS awareness for Women Self help Groups, HIV/AIDS awareness for adolescent girls, Youth Programme, Work place intervention and Training of Police personnel on HIV/AIDS. In tribal people Mass campaign, Kalajatha (Tribal folk songs, Street plays and Dramas) and one to one interaction are the main IEC activity practiced. They also use Borakatha to create awareness**.**

Diagnosis

107 VCTCs were setup in teaching hospitals, district hospitals and area hospitals where pre counseling and post counseling services are available. Government has sanctioned 113 more VCTCs in CHCs, which are being established. In sample the study district VCTCs were established in 5 places. One among these 5 is in tribal area i.e. in CHC, Araku.

Care & Support:

APSACS has set up 23 Care & Support Centres and 4 drop in centres to provide care & support services to the HIV positive persons. Counseling services, treatment for opportunistic infection and referral services are provided in the

Care & Support centres.In sample district APSACS has sanctioned one care and support centre at Kondala Agraharam. It is a 10-bedded centre; PLWHA can join and avail the treatment when ever necessary.

PLWHA net works:

District wise PLWA networks are being formed to cover all the districts. There are about 14 PLWHA networks formed including one at the state level covering 9 districts with around 9000 PLWHA as members.

ARV Drugs:

Three ARV Centre was established for providing free ARV drugs to HIV positive cases. (Osmania General Hospital, Govt. General Hospital, Guntur, **King George Hospital, Visakhapatnam**). In all the three centres, 7686 cases were registered and 1505 cases were given treatment by end of August, 2005.

Interventions focusing on vulnerable tribal communities

There is no special attention or programme for tribal people even at the state level. Even though the sample district has considerable amount of tribal population no separate programme has been designed to address the HIV/AIDS problem among the tribal. The intervention meant for migrant workers **and CSWs are** implemented in **Anathagiri and Araku** tribal mandals by an NGO called NATURE. With the interest of DLO, however, awareness campaign has been conducted regularly on Shandy days.

ANNEXURE 3.7: ASSESSMENT OF COMMUNICATION STRATEGIES FOR HIV/AIDS

According to the findings of CMS report[114], NACO division provides the leadership of all HIV/AIDS preventive IEC interventions. There are four guidelines developed by NACO, which are relevance for IEC division work. These are (i) Guidelines for using IEC channels by SACS (ii) Guidelines for CNA (iii) setting up of telephonic counseling services (iv) NGO guidelines for supporting NGO led IEC activities among high risk/marginalized target groups. These four together provide a framework for functioning of IEC divisions in SACS. NACO (IEC) Division also supports SAC (IEC) with basic national campaign material, manuals for training as well as with source material like FAQ and other booklets. It also provides themes for World AIDS Day and print and A/V material to the states and UTs. The States are expected to localize the contents where required and utilize them in their IEC effort. NACO has also collaborated with TV Health Magazine Programme, Prasar Bharati Channel, BBC WST and Directorate of Advertising and Visual Publicity (DAVP) to promote AIDS prevalence. At SACS level there is a format filled monthly, which gives the details of IEC material, activities and events such as World AIDS Day, Voluntary Blood Donation Day, FHAC and other activities. At SACS level there is another component within the TI format that details out the BCC activities done for targeted population. This is also a monthly form.

In the material reviewed, the study found that the communication was somewhat well focused and clear on "Routes of Transmission", "Prevention" and "Misconception" but when it came to "stigma", "discrimination", "care and support", the messaging in many places was less communicative. For example "I care.Do you" has been used without explaining the context. A NE state has a very effective folder on how to live positively with HIV". Generally low prevalence states have undertaken minimum level of communication effort on care and support. The study found VCTC related communication to be also low. There is token mention of MTVCT, not as PTCT.

Among TV Channels, DD is the most widely used channel by SACS. Radio is being used very widely as it is a less expensive medium. A large number of celebrity anchored messages have been made available by NACO. Some SACS have imaginatively used local celebrities. There is a wide variety of print literature- booklets, folders, leaflets, posters, stickers, etc. Under outdoors, hoardings have also been used by SACS.

In response to IEC efforts, the state analysis on HIV/AIDS awareness, effectiveness of different channels of communication and audience preferences, has shown that high prevalence states in comparison to low prevalence states generally reflect better general awareness levels. Perhaps prevalence itself is working for communication. On routes of transmission, particularly sexual route most widely associated with HIV/AIDS, there are awareness gaps. Evidences have shown that more communication is required on B of ABC (abstinence, be faithful, condom). On preventive methods, A and B has not been stressed effectively in communication. The study did not notice IEC efforts for HCPs before FHAC.

However, lot of efforts has gone into developing huge variety of IEC products, still a lot more to be done in this direction. NACO level understanding of IEC for BC for controlling the disease still needs to be percolated to SACS by providing more resources and further building the capacity at state level.

[114] CMS Report (2006): Moving Ahead: An Assessment of Current Communication Efforts & Strategies for HIV/AIDS: 1-25

ANNEXURE 3.8: Social Marketing Plan for NACP-III

"Prevention of new infections through a focus on high risk and vulnerable groups" is one of the four key areas identified under NACP-III Strategic framework. NACP-III may be interpreted as a giant behavior change program with a goal to reverse India's HIV/AIDS epidemic in 5 years time. Behavior change is required at all levels of society, from high risk groups (FSW, MSM and IDU) to vulnerable groups (youth, women etc). Social marketing is a behavioral change methodology which is particularly well equipped to address needs in the prevention component but can provide supportive elements in the area of care and support. Social marketing is the use of marketing principles and techniques to influence a target audience to voluntarily accept, reject, modify or abandon behaviour for the benefit of individuals groups or society as a whole. Social marketers sell behavioral change.

NACP-III represented three broad approaches of behavioral change- Education Marketing and Law. Education refers to educating people and encouraging voluntary adoption of a promoted behaviour; (Social) marketing refer to promoting and influencing behaviour change through the traditional 4 Ps of marketing—product, place, price, promotion- including development of attractive choices in products or services, pricing, channels of distribution; law refers to changes in law and policies of a recognized authority to create an enabling environment through advocacy for appropriate policies, legislation and practices which make delivery of needed education, products and services possible. The above approaches give an opportunity to a person to behave as promoted if institutional factors support; enable the person to perform a promoted behaviour if he/she possesses the required skill; motivates person to perform the behaviour.

Social marketing can play a lead behaviour change role among **high risk and vulnerable groups through**- provision of improved private STI services an promotion of better treatment seeking; provision and promotion of high quality, targeted VCT facilities in concert with targeted communication intervention; adoption of consistent condom use through targeted distribution and aggressive promotion. In addition to above, among IDU, social marketing has a role in increased adoption of safe injection practices through increased accessibility and promotion of clean injecting equipments and increased safer sexual practices with targeted condom distribution and promotion using the chemist channel and client communication. Similarly among MSM, social marketing can play a lead role through provision and promotion of the female condom which is stronger and reportedly preferable by many in this group. Under supportive role, social marketing may fulfill

- Encourage referrals for ART, TB, PMTCT from STI franchisees and VCT centres
- Recruitment of dedicated blood donors and branding and promotion of safe blood supplies
- Support to community-based groups for condom and lubricant supplies
- Promotion and operation of targeted HIV/AIDS help lines which provide referrals for those infected and affected, extend broad information campaigns and refer to essential services such as VCT, STI and facilities for ARVs.
- Analysis of the demand components for free or public services and recommendations for increasing utilization

Social marketing for high risk groups as lead behavioral change: Creative need exchange and safer sex communication programming for IDUs using the chemist channel and client communication. For supportive role: Through collaboration with community partners, extend private sector service and product networks for saturation of high risk locations (STI/VCT networks, female and male condoms). **For vulnerable populations as lead behaviour change**, creating efficient access to affordable, available, high quality condoms and services such as VCT and STI. Strengthen referrals for care and support, including ART, PMTCT. Increased demand for condoms through creative, targeted communication strategies that enhance the image of condom users and sellers and increase ability and confidence for condom use. Promote the use of qualified STI and VCT providers. The proposed social marketing plan for NACP-III aims at;

- retaining government mandate for condom procurement and distribution through social marketing organization (SMOs)
- Consensus required on utilizing the existing capacity within SMOs to undertake large scale, integrated social marketing for behaviour change. Orientation on social marketing and its disciplined methodologies are required at central and state levels
- Bridging the existing gaps in state and central level capacity—state would require technical support; centre would require policy, human resources, funding to provide systematic support for higher level social marketing efforts
- Coordination and integration of social marketing's strengths which would complement those of legal and education-based strategies[115]

[115] PSI Report (2006): Social Marketing Plan for NACP-III: 1-26

ANNEXURE 4.1: PROFILE OF PRIMARY ASSSESMENT AREAS

Rajasthan: In Rajasthan, district Dungarpur was covered. The total area of the district is 3,770 km². It has 4 tehsils and five blocks. All the five blocks (Dungarpur, Bichchiwara, Sagwara, Aspur and Simalwara) are dominated by the scheduled tribes. The distance of the five study tribal villages from district head quarter ranged between 6 Km and 35 Km. Every tribal village covered was having a primary school, a teacher (*Shiksha Mitra)*, a Anganwadi centre and a ANM visiting the village weekly. Some of the villages were having a high school and sub centre as well. Almost all the villages were having hand pump as a source of drinking water. Every village was also having a temple. Some of the villages were big in size and some were very small with the number of households varying from 80 to 1000 per village. Villages were sub-divided into social units called '*Falan'*. There were as many as 2-5 *Falans* in one village. Each *falan* had 50-200 households.

West Bengal: In West Bengal, district Purulia was selected. Purulia town, the district headquarter is located in the north of the Kasai river and is a major road and railway junction. The total area of the district is 6159 sq km. It has 6 development blocks. Of these 6 blocks, 4 blocks namely Santuri, Bagmundi, Manbazar –II, and Puncha are dominated by the scheduled tribes. Number of households in the study villages varied from 63 to 215 per village. Villages were subdivided into *Para*. There were about two-five *Paras* in one village and the size of each *Para* ranged between 50 and 100 households. Every tribal village had a primary school, AWC and an ANM visiting the village weekly. Some of the villages were having sub centre and private clinics. Almost all the villages were having hand pump and well as a source of drinking water. All the villages were connected with Kachchha road only. The distance of these villages from the district headquarter ranged between 42 and 65 kms.

Chhattisgarh: In Chhattisgarh, district Raipur was covered. The total area of the district is 13446 square kilometers. It has 13 tehsils and 15 development blocks. Of these 15 blocks, the scheduled tribes dominate three blocks namely Gariaband, Chhura and Mainpur. In all the study villages the houses were scattered. The villages had electricity and some houses also had television. These villages also had schools. As discussed with the village head though the tribes were not educated, recently they had started sending their children to school.

Andhra Pradesh: In AP the Visakhapatnam district was covered. The geographical area of the district is 11,161 sq.km.The district is separated in to 3 revenue divisions viz., 1. Visakhapatnam 2. Narsipatnam 3. Paderu. The entire Tribal area is under Paderu division that consists of 11 mandals. The mandals are Anantagiri, Araku, Dumbriguda, Hukumpet, Pedabayalu, Munchingipet, Paderu, G. Madagula, Chintapalli, G.K. Veedi and Koyyuru. The district has a population of about 38, 32,336 of which 13.2 percent comprises tribal population. The study was conducted in five villages, C colony village of Araku mandal, Gujalli village of Paderu mandal, Guntasema village of Dhumriguda mandal and Galaganda village of Pethabailu mandal and Kondiba village of Anathagiri mandal. The distance of the villages from their respective Mandal headquarters ranged between 8 and 18 km. All the five study villages had electricity. The houses are constructed using powdered charcoal and black mud.

Manipur: The study district, Churachandpur is located in the southwestern part of Manipur. The district is hilly spread over an area of 4570 Sq.km. There are total five sub divisions and 6 tribal development blocks. The study villages were at a distance ranging from 7 to 31 km from the district headquarters. The number of houses in the villages ranged between 70 and 300. The settlement pattern was scattered. The village has electricity facility, schools, one AWC, post office, shops and churches.

Maharashtra: In Maharashtra, district Thane was covered. The total area of the district is 9558 Sq. k.m. square kilometers. It has 13 blocks. Thane, Kalyan, Ulhasnagar, Bhiwandi, Vasai are the industrially developed tehsils and mostly urbanised. On the contrary, Talasari, Jawhar, Mokhada, Dahanu, Wada and Palyhar are Tribal Talukas/Blocks having maximum tribal population. The study area covered under the study was Talaseri Taluk of Thane district. This Taluk is situated on the Mumbai - Ahmedabad NH8. All the study villages had a Primary school and AWCs. Primary health services were available in all the study villages. Three of the villages were large enough to have Primary Health Centres within the villages. In the remaining two people had to travel for 5 to 10 km to access the PHC services. Only one village had a registered medical practitioner.. None of the villages had a STI specialist. Availability of quacks was reported in three villages. Only two villages had a traditional healer. The tribal people frequented the traditional healers. Approach roads to all villages were pucca and made of coal tar. One village had access to middle/ high school that was about 15 km away. All the villages by and large had electricity. Three of the five villages under study had a post office within village.

ANNEXURE 4.2: SOCIO-ECONOMIC PROFILE OF TRIBAL PEOPLE

During the discussion with community as well as the consultations with the secondary stakeholders in **Rajasthan** it emerged that in earlier times the tribal people was dependent on the forest for their livelihood. Presently agriculture and agricultural labor were the main occupation of the men folk in the community. Since agriculture is dependent on monsoons, during the non – monsoons period the men were forced to undertake seasonal migration. Most of the tribals migrated to urban areas of Gujarat and Maharashtra, Ahmedabad, Anand and Surat (Gujarat) and Pali (Mumbai). They were reported to be living together (generally 3-4 in one room) and working in hotels, mines and building construction. Women looked after the households and were also actively engaged in family occupations. Women generally did not migrate. During a discussion with an academician, it was found that a few women also migrated along with the men and returned during festivals.

In **West Bengal** since there are no industrues, the major occupation was agriculture and animal husbandry. They collected wood from the forests and sold in the markets. During lean months, they shifted to manual labor in coal mines, construction, brick making etc. to nearby places like Burdwan, Kalna, Jamshedpur, Ranchi etc. and even to far off places like Maharashtra or Tamil Nadu. Instances of migration to other places for work were few and inconsistent. Migration generally took place in groups. Both men and women in the age group of 15-24 years migrated. The average monthly income of the tribal people ranged from Rs. 600 to 1200 per month. Most of the women also worked in the field as agricultural labourers apart from doing their daily household chores. Some of them went to the forset to collect wood.

In **Chhattisgarh** the tribals were mostly engaged in agriculture labour termed as "*krishi majdoori*". They were also engaged in making bamboo baskets. During the lean agricultural season, they migrated to neighboring areas. They also domesticated animals. Though the tribals were not educated, recently they had started sending their children to school.

The tribals of **Andhra Pradesh** were engaged in agro-forest activities. They raised plants and domesticate animals. With the introduction of cash economy and marketing system the tribal are forcefully selling some part of their produce in the markets to buy certain essential commodities. Dry land and shifting (*podu*) cultivation was prevalent. The majority of the people grew Paddy and Ragi. During the lean agriculture period they migrated to other places for labour work. Though most of them migrated to near by places, very few also migrated to far off places like Vishakhapatnam and Vijayanagarm. The women were mostly engaged in collection of leaves (*Adda* leaves), which were sold at the "*shandy*" (market place).

In the district of **Manipur** the system of hereditary chief ship as well as community ownership of village land is prevalent. In case of hereditary chief ship the chief is all-powerful, as he controls not only the economy of the village through his ownership of the land but exercises social control over the households in the village. An overwhelming majority of the tribal people has converted to Christianity. Women played a significant role in agriculture and animal husbandry, besides being actively involved in weaving. The tribal communities usually did not go out for work. They were also engaged in stone breaking. Their monthly income ranged between Rs. 1000 and Rs 1500.

In **Maharashtra** the study area did not have any industrial setups within the Taluk, hence inhabitants mostly belonged to lower socio economic groups. The region had palm trees from which toddy was extracted and sold in the market in the form of alcohol. In spite of being situated on NH8, Talasari did not have many facilities. Main occupation in the study areas was farming during monsoons. During dry season they migrated to outer areas of Mumbai and Thane like - Palghar, Bhivandi, Vasai, Virar and Bhayender to work in salt pans or construction industry. The industrial belt of Vapi, Silvassa and Dadra and Nagar Haveli also attracted a number of locals to work in factories producing variety of small and big products. The ones who lived away for longer periods usually returned to their hometowns during festivals like Holi and Diwali. Wages earned usually ranged from Rs. 100-150 per day.

Annexure 4.3 Distribution of districts with > 50 % ST population by HIV prevalence categories

Category	Prevalance	Districts with <50% ST population (Out of NACP districts)		Districts with >50% ST population (Out of NACP districts)	
		Number	Name	Number	Name
A	High prevalence	130	Nizamabad, Karimnagar, Medak, Hyderabad, Rangareddi, Nalgonda, Warangal, Khammam, Srikakulam, Vizianagaram, Visakhapatnam, East Godavari, West Godavari, Krishna, Guntur, Prakasam, Nellore, Cuddapah, Kurnool, Anantapur, Chittoor, Khagaria, Madhubani, Sitamarhi, Muzaffarpur, Purba Champaran, Pashchim Champaran, Kishanganj, Purnia, Mahasamund *, Mahesana, Surendranagar, Patan *, Surat, Navsari *, Mandya, Bangalore, Hassan, Bijapur, Uttara Kannada, Bangalore Rural, Dakshina Kannada, Udupi *, Dharwad, Bagalkot *, Gulbarga, Gadag *,Belgaum, Tumkur, Kolar, Kodagu, Haveri *, Mysore, Chamarajanagar *, Koppal, Davanagere, Bidar, Chitradurga, Bellary, Raichur, Ernakulam, North Goa, South Goa, Kolhapur, Mumbai, Sangli, Satara, Mumbai (Suburban) *, Bid, Ratnagiri, Solapur, Osmanabad, Jalna, Latur, Parbhani, Aurangabad, Pune, Akola, Ahmadnagar, Bhandara, Hingoli *, Nanded, Nagpur, Jalgaon, Raigarh, Wardha, Thane, Chandrapur, Yavatmal, Nashik, Dhule, Gadchiroli, Bishnupur, Imphal West, Imphal East *, Ujjain, Mandsaur, Bhopal, Indore, Jabalpur, Ganjam, Cuttack, Sambalpur, Ganganagar, Ajmer, Jhalawar, Pudukkottai, Ramanathapuram, Theni *, Chennai, Karur *, Thanjavur, Nagapattinam *, Madurai, Tirunelveli, Kanniyakumari, Cuddalore, Perambalur *, Coimbatore, Tiruchirappalli, Kancheepuram, Dharmapuri, Tiruvannamalai, Namakkal *, Salem, Balrampur *, Kolkata, Hugli,	22	Bastar, Valsad, The Dangs, Nandurbar *, Senapati (Excluding 3 Sub-Divisions), Chandel, Churachandpur, Tamenglong, Kolasib *, Aizawl, Mamit *, Lunglei, Lawngtlai, Saiha *, Champhai *, Serchhip *, Dimapur *, Kohima, Mokokchung, Mon, Tuensang, Zunheboto,
B	Moderate prevalence	48	Kamrup, **Patna, Kaimur (Bhabua) *, Diu, Amreli, Bhavnagar, Rajkot, Jamnagar, Junagadh, Ahmadabad, Porbandar *, Anand *, Gandhinagar, Kheda, Sabar Kantha, Panch Mahals, Bharuch, Doda, Alappuzha, Thrissur, Kozhikode, Pathanamthitta, Thiruvananthapuram, Kottayam, Sindhudurg, Buldana, Washim *, Amravati, Gondiya *, Neemuch *, Rewa,** Khordha *, Sikar, Barmer, Alwar, Tonk, Sirohi, South (Sikkim), West (Sikkim), Thiruvarur, Dindigul, Thiruvallur, North Tripura, Agra, Ghazipur, Murshidabad, Barddhaman, Jalpaiguri	3	Dohad *, Narmada *, Banswara

C	Highly Vulnerable	195	Adilabad, Mahbubnagar, Changlang, Lohit, West Kameng, Cachar, 'Dhubri, Sibsagar, Barpeta, Golaghat, Bongaigaon, Jorhat, Goalpara, Lakhimpur, Kokrajhar, Dhemaji, Sheohar *, Darbhanga, Sheikhpura *, Begusarai, Gaya, Jehanabad, Samastipur, Vaishali, Nawada, Saran, Gopalganj, Supaul *, Saharsa, Bhojpur, Madhepura, Lakhisarai *, Rohtas, Araria, Munger, Banka *, Jamui *, Katihar, Raipur, Kawardha *, Dhamtari *, Raigarh, Korba *, Kachchh, Una, Shimla, Mandi, Kullu, Chamba, Jammu, Srinagar, Kupwara, Anantnag, Rajauri, Chatra *, Dhanbad, Giridih, Bokaro, Godda, Ranchi, Pakaur *, Shimoga, Chikmagalur, Kollam, Malappuram, Kannur, Palakkad, Kasaragod, Idukki, Wayanad, Thoubal, Bhind, Morena, Shajapur, Gwalior, Rajgarh, Sagar, Sehore, Shivpuri, Satna, Hoshangabad, Dewas, Sheopur *, Katni *, Ratlam, Harda *, Chhindwara, Seoni, Betul, Shahdol, Puri, Kendrapara *, Jagatsinghapur *, Bhadrak *, Nayagarh *, Jajapur *, Sonapur *, Baleshwar, Anugul *, Baudh *, Dhenkanal, Kalahandi, Debagarh *, Nuapada *, Kendujhar, Koraput, Hanumangarh *, Bharatpur, Dhaulpur, Bhilwara, Rajsamand *, Karauli *, Udaipur, Sivaganga, Virudhunagar, Thoothukkudi, Vellore, West Tripura, South Tripura , Pratapgarh, Hardoi, Bulandshahar, Gonda, Kaushambi *, Aligarh, Meerut, Moradabad, Faizabad, Mahoba *, Firozabad, Jaunpur, Jalaun, Ballia, Sitapur, Bareilly, Mathura, Siddharthnagar, Basti, Kushinagar *, Sultanpur, Chandauli *, Sant Ravidas Nagar Bhadoh, Barabanki, Saharanpur, Azamgarh, Rampur, Deoria, Fatehpur, Sant Kabir Nagar *, Mau, Gorakhpur, Kanpur Dehat, Varanasi, Gautam Buddha Nagar *, Sonbhadra, Unnao, Kanpur Nagar, Farrukhabad, Jhansi, Mirzapur, Rae Bareli, Bijnor, Lucknow, Allahabad, Pilibhit, Mahrajganj, Bahraich, Shrawasti *, Kheri, Rudraprayag *, Tehri Garhwal, Almora, Hardwar, Garhwal, Champawat, Nainital, Bageshwar, Uttarkashi, Chamoli, Pithoragarh, Dehradun, Udham Singh Nagar *, Haora, Koch Bihar, South Twenty Four Parganas, North Twenty Four Parganas, Nadia, Uttar Dinajpur, Birbhum, Maldah, Medinipur, Bankura, Darjiling, Dakshin Dinajpur *, Puruliya	29	Nicobars, Papum Pare *, East Siang, Tirap, 'Karbi Anglong, Dadra & Nagar Haveli, Surguja, Jashpur *, Dantewada*, Kinnaur, Kargil, Pashchimi Singhbhum, Lakshadweep, Dhar, Barwani *, Wokha, Sundargarh, Nabarangapur *, Rayagada *, Mayurbhanj, Malkangiri *, West Garo Hills, East Khasi Hills, Ri Bhoi *, South Garo Hills *, Jaintia Hills, East Garo Hills, West Khasi Hills
D	Vulnerable	80	Andamans, Dibang Valley, 'Hailakandi, 'Karimganj, 'Nagaon, 'Tinsukia, Dibrugarh, Sonitpur, Marigaon, Darrang, Nalbari, Nalanda, Aurangabad, Siwan, Buxar *, Bhagalpur, Janjgir - Champa*, Durg, Bilaspur, Rajnandgaon, Koriya *, Daman, Hamirpur, Kangra, Solan, Sirmaur, Bilaspur, Badgam, Pulwama, Kathua, Baramula, Udhampur, Punch, Kodarma *, Hazaribagh, Deoghar, Garhwa, Palamu, Purbi Singhbhum, Sahibganj, Dumka, Datia, Chhatarpur, Tikamgarh, Vidisha, Guna, Damoh, Narsimhapur, Panna, Raisen, Balaghat, Sidhi, Umaria *, Bargarh *, Jharsuguda *, Nagaur, Bikaner, Churu, Jhunjhunun, Jodhpur, Jaisalmer, Pali, Jaipur, Jalor, Kota, Bundi, Baran *, Chittaurgarh, Sawai Madhopur, Dausa *, East (Sikkim), Erode, Ariyalur *, Viluppuram, The Nilgiris, Hathras *, Auraiya *, Ambedkar Nagar *	21	Tawang, Upper Siang *, West Siang, East Kameng, Upper Subansiri, Lower Subansiri, 'North Cachar Hills, Kanker *, Lahul & Spiti, Leh (Ladakh), Lohardaga, Gumla, Ukhrul, Mandla, Dindori *, Jhabua, Phek, Gajapati *, Kandhamal, Dungarpur, North (Sikkim)
E	None	5	Vadodara, KARNATAKA, West Nimar, East Nimar, Hamirpur,		

Total districts as per NACO list	608
Total districts as per census 2001	593
Distrcits not mentioned/matched in Census 2001	15
Districts with < 50%ST	453
Districts with > 50%ST	75
Districts with "0"ST pop	60
Districts not belonging to any risk prevalence category	5

ANNEXURE 5.1: MANIPUR STATE LEVEL POLICY ON HIV/AIDS

Manipur is the only state in the country having the State level policy on HIV/AIDS as it poses a serious threat to public health. The focus of national AIDS policy is on harm minimization, where as the Manipur has it policy base-harm reduction through measures like drug maintenance therapy and needle syringe exchange programme. The other components of the state AIDS policy are;

- Provision of accurate information and education to create awareness and to protect themselves from HIV infection.
- Voluntary participation of people with HIV/AIDS
- Safeguard of confidentiality
- Respect for privacy, human dignity and individual human rights
- Avoidance of discrimination and stigmatization
- Provision of quality medical care
- Provision of social benefits and social support system for people with HIV/AIDS
- Creating helpful, supportive and enabling social environment in the community
- Avoidance/removal of fear psychosis in the mind of people, that is, it does not support any kind of compulsory testing of HRGs, pre–employment or employment but encourages pre-marital testing with informed consent and appropriate counseling.

Multi-sectoral approach: The state will have three state level committees (State AIDS Committee, State Empowered Committee and Sate level AIDS Co-ordination policy) and one district level committee (District AIDS Committee). These committees will have representatives from various government departments (Education, Social Welfare, Home, Health, Family Welfare, Youth Affairs and Sports, DIPR, MAHUD, Rural Development, Tribal Development, NGO representative as members, IMA, Nurses Associations, Media agencies. Women's organizations, NGOs, Panchayat representatives, Village Authority and NGO representative as members).

IEC: The Health Department will play a leadership role in implementing the IEC Strategy. All IEC materials will be produced in Manipur, major tribal dialects, English or any other language spoken by the target group of people to ensure widespread understanding, suitability, acceptability and popularity among people. The Department of Health will follow an intensive and systematic approach for informing the youths, the students, and the women in the reproductive age group and general population through various media channels to enable them to protect themselves from HIV infection and to obtain help as easily as possible. Targeted massages will be given to the people with high risk behaviours such as Injecting Drug Users (IDUs), Commercial Sex Workers (CSWs) etc. so that they may choose the intervention options which may reduce the risk of HIV infections. Various communication channels such as print media including newspapers and journals, electronic media like, T.V. Radio, Films, Video and Audio cassettes and traditional media like Shumang Lila, Dramas, Folk Plays, Music Ensembles etc. shall be used.

STD: The STD control programme will be integrated with the AIDS control programme. The STD clinic staff will be given adequate training and orientation to make the clinics user-friendly. The existing STD clinics will be strengthened and equipped properly in order to provide an effective referral support to the programme. Syndromic approach in STD control programme will be introduced in all PHCs, CHCs, District Hospitals, MCH Clinics etc. So that STD treatment services are made easily accessible to the people who need it. All doctors including private practitioners and paramedics will be trained in syndromic approach of STD treatment.

DRUG ABUSE TREATMENT: De-addiction Centres will be established for detoxification, de-addiction treatment of Drug Users, Injecting Drug Users etc. at appropriate places. Withdrawal or total or lasting abstinence is the goal in the treatment of IDUs but short-term intervention options, harm reduction measures will be made available for those drug users who are not physically and psychologically ready for abstinence. Various treatment options such as complete abstinence from drugs, safer Drug maintenance, safer injecting practices etc. may be examined and implemented taking into consideration the local situations, technical, social, political and economic feasibilities. Rehabilitation and training on stress management skills, survival skills of recovering drug users, people with HIV/AIDS will be tied up with employment oriented schemes/programmes of other development departments.

EMPLOYEMENT: There shall be no discrimination in recruitment against applications on the grounds that the application has HIV or AIDS. No information will be sought under any circumstances regarding a person's HIV status.

No employee or applicant shall be required to take the HIV antibody test. An applicant's medical fitness for employment will be assessed by the existing normal procedure. No employee shall be required to divulge his/her HIV status to his/her employer. Any variation in the conditions of employment or deployment of duties of HIV positive employees will be decided on the basis of "medical fitness" and after consultation with the State AIDS Authority.

CONFIDENTIALITY: Street confidentially about a person's HIV status whether HIV positive or negative will be ensured. No information will be released without his or her written consent or only on subpoena by the Law Court. Breach of confidentially by the staff will be taken as a disciplinary matter and will be dealt with under the disciplinary procedure.

SOCIAL SERVICE PROVISION: No one will be denied of service such as education, accommodation, housing, travel, hospital services and social service benefits to which he/she is entitles solely because of his/her HIV status. The State government will review the existing policies and practices in the Government department in order to ensure that the employees are adequately protected against HIV infection. The State Government is committed to the active involvement of people living with HIV/AIDS in their own care and in the implementation of the programme.

NON DISCRIMINATION: No patient will be denied of hospital admission, treatment, operation, delivery, investigations etc. solely on the ground of his/her HIV status. Respect for privacy, dignity, individual human rights and non-discrimination of people with HIV/AIDS will be ensured.

LEGAL FRAMEWORK: Appropriate legislation will be initiated for proper and effective implementation of the National AIDS Control programme in the State in the light of this State AIDS policy[116].

[116] About AIDS In Manipur, Manipur State AIDS Policy http://imphaleast.nic.in/aidshome.htm

STAKEHOLDER CONSULTATION PLAN

Sl. No.	Details	Responsible Organisation	Time Line
1.	Identification of the stakeholders considering • Available list from the stakeholder consultation – Social Assessment of HIV/AIDS among Tribal People in India organized by NACP III, NACO with the help of RCSHA, 13th-14th June, 2006) • Finalising the list by adding representatives from Adivasi network/social networks, institutes focusing vulnerable • Formation of national and regional stakeholder consultation group	• NACO with support from funding agency • Social Development Officer/Tribal Liaison Officer at NACO	By the end of first 3 months of NACP III
2.	First National Stakeholder Consultation – Discuss findings of • Social Assessment Report focusing Tribal People, and • Rural Populations	• NACP III, NACO • Support from RCSHA	Activity completed
3.	Second National Stakeholder Consultation - Discuss • Pro-tribal focus and social dimensions in the policies • Integrated HIV/AIDS services / convergence plan • Advocacy plan	• NACP III, NACO • Support from Funding agencies	By the end of 6 months of NACP III implementation
4.	First Regional Consultation • East (Bihar, Jharkhand, Orissa, West Bengal) • North East (Seven States) • West (Gujarat, Maharashtra, Goa, Daman & Diu, Dadra & Nagar Haveli) • South (Tamil Nadu, AP, Karnataka, Kerala, Laksha Dweep, Andaman & Nicobar, Pondicherry) • Central (Madhya Pradesh, Chattisgarh) • North (UP, Rajasthan, Himachal Pradesh, J&K, Punjab & Haryana) Focus: • Making available the mapping/research/TNA reports • Presentations on some important studies • Seek opinions on draft strategies formulated for care and support services • Seek opinions on vulnerable tribal populations identified for interventions	• NACP III, NACO • SACS to host on rotation basis • Support from Funding agencies	First Quarter of Second Year

5.	Second Regional Consultations Focus: • Making available the surveillance reports • Presentations on documentation of interventions • Seek opinions on the services being rendered and corrective measures to be taken • Seek opinions on intervention processes and corrective measures to be taken	• NACP III, NACO • SACS to host on rotation basis • Support from Funding agencies	Last Quarter of the third Year

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