

TRAINING MODULE FOR SCALING UP SOCIAL PROTECTION FOR PEOPLE INFECTED WITH AND AFFECTED BY HIV/AIDS

Preventive
Schemes

Protective
Schemes

Promotive
Schemes

Inclusive
Schemes

Exclusive
Schemes



TRAINING MODULE FOR SCALING UP SOCIAL PROTECTION FOR PEOPLE INFECTED WITH AND AFFECTED BY HIV/AIDS



वी. हेकाली झिमोमी, भा.प्र.से.
अपर सचिव एवं महानिदेशक
V. Hekali Zhimomi, IAS
Additional Secretary & Director General

75
आज़ादी का
अमृत महोत्सव



Foreword

As we are progressing towards achieving our goal of an AIDS-free India, it is crucial that we address the social and economic barriers faced by those infected with and affected by HIV and AIDS and the High Risk Groups (HRG). The National AIDS Control Organisation (NACO) has been working towards ensuring that every individual has equal access to all healthcare and support services without facing HIV-related stigma and discrimination.

One of the major challenges faced by people living with HIV and HRGs is the lack of access to Social Protection benefits. Many of them belong to marginalized communities and face stigma and discrimination from many corners of society. Studies across the world, indicate that, improvement in the quality of life leads to significant reduction in vulnerability with regard to HIV infection among the HRGs and helps to increase the life span of PLHIV. The Social Protection Training Module developed by NACO is a step in this direction. It equips the key officials of the State AIDS Control Societies and other important stakeholders with the necessary skills to integrate Social Protection interventions into their existing programmes.

The training module covers a wide range of topics including the concept of Social Protection, resource mapping, capacity building and the role of key officials in linking the individuals with these schemes. The module also emphasizes the importance of mainstreaming Social Protection interventions to ensure that the vulnerable communities receive the necessary support to manage disease burden.

Thus, the module aims at reducing vulnerability among the people infected with and affected by HIV and AIDS and the HRGs by providing better access to the existing Social Protection schemes provided by the Central and State Governments. The module is also directed towards empowering these communities by providing them with knowledge about their rights and entitlements under the Social Protection schemes. This training module will support all the State AIDS Control Societies' key officials to initiate and integrate Social Protection interventions within their respective work in the State/UTs.

I commend my colleagues in NACO for taking this important initiative towards creating a more inclusive and supportive environment for those affected by HIV and AIDS. I would also extend my gratitude to UNDP India for their support in developing this module. I urge all key officials of the State AIDS Control Societies to make use of this training module and play their part in making India a more equitable and compassionate society. By working together, we can ensure that no one is left behind in the fight against HIV and AIDS.


(V. Hekali Zhimomi)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel.: 011-23325331 Fax : 011-23351700

E-mail: dgoffice@naco.gov.in

अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

Know your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing



निधि केसरवानी, भा.प्र.से
निदेशक
Nidhi Kesarwani, I.A.S.
Director



PREFACE

NACO has been at the forefront in the fight against HIV epidemic in India. The impact of the National AIDS Control Programme implemented by NACO has been significant and is globally acclaimed. One of the goals of NACP Phase-V (2021-26) is to accelerate the progress on elimination of HIV/AIDS related stigma and discrimination. One of the approaches adopted to reduce stigma and discrimination is through promoting and scaling up of Social Protection schemes for the people infected with and affected by HIV/AIDS and the High Risk Groups.

The HIV epidemic has disproportionately affected these communities, making them more vulnerable to poverty, stigma, and discrimination. Thus, Social Protection is viewed with great importance for reducing vulnerabilities and to mitigate the impact of HIV. The Social Protection schemes extended by the Central and State Government can play a critical role in reducing vulnerability and improving the quality of life for the marginalized communities.

I am delighted to introduce this training module on Social Protection interventions for the officials of State AIDS Control Societies and key stakeholders. The aim of this module is to equip the officials and other stakeholders with the necessary skills and knowledge to integrate Social Protection interventions with the existing HIV and AIDS interventions in the State/UTs. This module will equip the officials with the necessary knowledge and skills to identify and address the Social Protection needs of the communities they serve.

I congratulate the IEC & MS team at NACO and UNDP for their efforts in developing this training module. I hope that the SACS officials make the most of this opportunity and apply the knowledge gained to bring about positive changes in the lives of the people infected with and affected by HIV/AIDS and the High Risk Groups.

Together, we can work towards a more inclusive and equitable society, where every individual has access to the necessary support and resources to lead a dignified life.


(Nidhi Kesarwani)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel.: 011-23325331 Fax : 011-23351700

E-mail: dgoffice@naco.gov.in

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Know your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing



Dr. Anoop Kumar Puri
MBBS, MD
Deputy Director General
Tel.: +91-11-23731805
Fax : +91-11-23731746
Mob : 9899143711



भारत सरकार
वास्थ्य और परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
आ तल, चन्द्रलोक बिल्डिंग, 36, जना
नई दिल्ली - 110001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
6th Floor, Chandralok Building,
36, Janpath, New Delhi - 110001

ACKNOWLEDGEMENT

The National AIDS Control Organisation Ministry of Health & Family Welfare, Government of India with the support of UNDP has developed a training module for the key officials of State AIDS Control Societies and other stakeholders to integrate and scale-up Social Protection interventions for the people infected with and affected by HIV/AIDS. The objective of the module is to reduce the vulnerability among the PLHIV and affected community by providing support and better access to the Social Protection schemes at the Central and State level.

We place on record our sincere gratitude to Ms. V Hekali Zhimami, Additional Secretary & Director General NACO and Ms. Nidhi Kesarwani, Director NACO for providing their vision and insights in the development of this training module. Dr. Bhawna Rao (Deputy Director- IEC & MS), Ms Nidhi Rawat (National Consultant-IEC&MS), Mr Utpal Das (Consultant- IEC&MS), Ms. Shuchi Gautam (Associate Consultant-IEC&MS), Ms. Ira Madan (Technical Expert-Prevention), Mr. Samresh Kumar (Technical Expert Prevention) who were instrumental in providing programmatic context and actively engaging in the process of preparing the module.

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(Dr. Anoop Kumar Puri)



MESSAGE

It is a well-established fact that HIV/AIDS is not only a health issue, but also a social and developmental challenge. We need to address these issues if we are to end HIV/AIDS as a public health threat by 2030. This is why the Global AIDS Strategy 2021-26, by the Joint UN Programme on HIV/AIDS (UNAIDS), has adopted an inequalities lens in its approach to AIDS response. The strategy focusses on addressing issues like stigma, discrimination, punitive laws and providing services including Social Protection, in line with the 10-10-10 targets.

The National AIDS Control Programme (NACP) which is implemented by the National AIDS Control Organization (NACO), Ministry of Health and Family Welfare (MoHFW), has consistently prioritized HIV-sensitive Social Protection in its various phases of implementation. As part of the National AIDS and STD Control Programme, Phase-V (2021-2026), Goal 5 specifically focuses on the elimination of HIV/AIDS-related stigma and discrimination, calling for engagement with state governments to initiate and expand Social Protection schemes.

UNDP has been a long-standing partner of NACO in its HIV mainstreaming and Social Protection interventions. We are proud of our collaboration on projects like piloting the single window model of Social Protection and facilitation of COVID-19 related schemes among PLHIV and key populations. The COVID-19 pandemic has further reinforced the need for enhancing access to Social Protection measures among these vulnerable groups. A capacity needs assessment conducted by NACO in collaboration with UNDP during this period highlighted the necessity for capacity building among officials from State AIDS Control Societies (SACS) to effectively implement HIV-sensitive Social Protection measures.

Against this backdrop, it gives me great pleasure to support the development of this important training module on Social Protection for SACS officials and stakeholders, which aims to enhance the capabilities of officials and other stakeholders in facilitating HIV-sensitive Social Protection. As a co-sponsor of UNAIDS, UNDP is honored to support MoHFW and NACO in this initiative. I am confident that this document will act as a guide in ensuring that we truly leave no one behind.



Shoko Noda
Resident Representative

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behavior Change communication
CB	Capacity Building
CGAS	Central Government Assisted Schemes
CBO	Community Based Organization
CMIS	Computerized Management Information system
CNA	Capacity Needs Assessment Study
CSO	Civil Society Organization
CSWB	Central Social Welfare Board
DAPCU	District AIDS Prevention Control Unit
DISHA	District Integrated Strategy for HIV/AIDS
EE	Enabling Environment
IEC	Information Education and Communication
FBO	Faith Based Organization
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV
HIV	Human Immune-deficiency Virus
HRG	High risk Groups
IDU	Injecting Drug Users
ICTC	Integrated Counseling and Testing Centers
ICPS	Integrated Child Protection Schemes
MSM	Men having Sex with Men
NACP	National AIDS Control Programme
NACO	National AIDS Control Organisation
NCA	National Council on AIDS
NGO	Non Governmental Organization
NHM	National Health Mission
NSEP	Needle Syringe Exchange Programme
NWC	National Women Commission
OI	Opportunistic Infections
ORW	Outreach Worker
OST	Oral Substitution Therapy
PE	Peer Educator
PLHIV	People Living with HIV
PD	Project Director
PM	Project Manager
RBA	Right Based Approach
SACS	State AIDS Control Society
SCA	State Council on AIDS
SM	Social Marketing
STI	Sexually Transmitted Infections
TI	Targeted Intervention
SETU	Strategic Expertise Technical Unit
UNDP	United Nations Development Programme

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PART

1

**Facilitation
Guidelines**



1. Rationale

Since the diagnosis of the first HIV/AIDS cases in the early 1980s, understanding of the epidemic has passed through several stages. Over the last two decades, India's National AIDS Control Programme (NACP) has evolved and expanded to provide HIV prevention, testing and treatment services countrywide. Scaling up has been uniform across all strategic components and has not only halted, but also reversed, the spread of the epidemic and ensured a major reduction in the number of AIDS-related annual deaths. As the epidemic has been driven by High Risk Groups, there has been a special focus on these groups from the outset, with various innovative strategies for prevention and testing services. The treatment component has also been scaled up over the years through various models of service delivery that ensured access to free antiretroviral therapy for eligible HIV-infected patients. The programme is currently in its fifth phase.

The first phase of NACP focused on raising awareness and ensuring the safety of blood. The second phase saw direct interventions launched across the prevention-detection-treatment continuum, along with State's capacity for programme administration being built. The third phase was a scaling-up tale, with programme administration devolved all the way down to the district level. Consolidation and increased Government funding marked the fourth phase. The need for continued action and vigilance in the context of the country's resolve to eliminate the AIDS epidemic as a public health issue by 2030 prompted the development of NACP Phase-V.

The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The NACP Phase-V also aims to attain dual elimination of vertical transmission of HIV and Syphilis, elimination of HIV/AIDS related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations. Under NACP Phase-V, while the existing interventions will be sustained, optimized, and augmented; newer strategies will be adopted, piloted, and scaled-up under the programme to respond to the geographic and community specific-needs and priorities. Under the goal 5 of NACP Phase-V, it intends to accelerate the progress on elimination of HIV/AIDS related stigma and discrimination. The HIV and AIDS (Prevention & Control) Act, 2017, a Central legislation protecting and promoting the rights of persons infected with and affected by HIV and AIDS came into force in the 10th September 2018. The objectives of the Act are to prevent and control the spread of HIV and AIDS and for reinforcing the legal and human rights of persons infected with and affected by HIV and AIDS. It also seeks to protect the rights of healthcare providers. The Act addresses stigma & discrimination and strives to create an enabling environment for enhancing access to services. It provides for diagnostic facilities related to ART and opportunistic infection management to people living with HIV and AIDS. The Act also provides for a robust grievance redressal mechanism in the form of Ombudsman at the State level and Complaints Officer at the establishment level aiming to provide speedy redressal.

At the national level, estimated adult HIV prevalence (15-49 years) has declined since the epidemic's peak in 2000 where prevalence was estimated at 0.55% in 2000, through to 0.32% in 2010, and 0.21% in 2021. These States have the highest adult HIV prevalence (2.70% in Mizoram, 1.36% in Nagaland and 1.05% in Manipur), followed by southern States

(0.67% in Andhra Pradesh, 0.47% in Telangana and 0.46% in Karnataka). The number of People Living with HIV (PLHIV) are estimated at around 24 lakhs. Other states have the largest number of PLHIV viz. Maharashtra, Andhra Pradesh and Karnataka being the top three. Annual New Infection (ANI) are estimated at 62.97 thousand in 2021 in India. There is an estimated 46.3% decline in ANI at national level from 2010-2021. A declining trend is noted in most States. Top 3 States with most rapid decline is Himachal Pradesh (with around 73% decline from 2010-2021), Tamil Nadu (around 72% decline), Telangana (nearly 71% decline).

While the overall adult prevalence remains low, (0.21% in 2021), HIV prevalence among high-risk groups and bridge populations remains very high. HIV prevalence among migrants is 4 times, among truckers is 5 times, among inmates of Prisons and Female Sex Workers (FSW) is 9 times, among men who have sex with men is 16 times, among transgender people, it is 18 times, and among injecting drug users, it is 43 times of the overall adult HIV prevalence. However, it continues to be disproportionately high for the north-eastern region of India with three, Mizoram, Nagaland, Manipur continuously having adult HIV prevalence of more than 1%. (Source: Sankalp, Status of National AIDS Response, Fourth Edition 2022)

While at the outset HIV/AIDS was mainly considered a public health issue, it is now seen as a development concern of the highest priority, requiring a multi-sectoral approach and response that focus not only on how the virus is transmitted, but also on the factors that render people and communities vulnerable.

1.1. NACP-II - Setting Up of Mainstreaming Process

National AIDS Control Programme Phase II (1999-2007), while focusing on reducing the spread of HIV infection by stressing on prevention and behaviour change, also called attention to the need for expanding capacity to respond to HIV/AIDS on a long-term basis. The infection no longer restricting itself to high risk groups spread to the general population, from urban to rural areas and amongst the population in the 15-49 years age group – the backbone of the nation's productivity. The huge number of migrant labour and their living conditions also necessitated a focused approach and therefore mainstreaming, as a separate strategy linked to the overall national response, was adopted.

The outcome of intensive deliberations with stakeholders was the decision to identify key government ministries, non-health civil society organisations (including Faith Based Organisations) and the members of industry to reach out to the target population with prevention messages. A multi-sectoral approach forming the backbone of the mainstreaming strategy was therefore adopted.

Strong political commitment followed the formation of the National Council on AIDS in 2005, comprising 31 Ministries, 7 Chief Ministers and leading civil society representatives under the chairmanship of the Hon'ble Prime Minister of India. The overarching goal of the NCA is to facilitate multi-sectoral response to the epidemic, making HIV a development challenge and not merely a public health problem. The programme approach was increasingly shaped towards decentralization by establishing State Council on AIDS and involvement of NGOs, civil society partners, private sector and networks of People Living with HIV/AIDS (PLHIV).

1.2. NACP-III - Giving Structure to Mainstreaming & Systems Strengthening

As part of the third phase of the national programme, it was decided to provide a larger impetus to mainstreaming. Accordingly, a formal structure was put in place to include a central Mainstreaming Cell at NACO which would help achieve mainstreaming objectives with support from State Mainstreaming Units and other staff in the State AIDS Control Societies.

Since its inception in April 2007, the Mainstreaming Cell has been engaging Government agencies, private sector and Civil Society Organisations towards adopting HIV interventions in their place of work as well as with those they associate with. The process of this work entails establishing systems and procedures, creating linkages and developing capacities of partners and other associated stakeholders.

1.3. NACP IV - Strategies for Mainstreaming and Partnership

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

- **Mainstreaming for prevention** Provide information on HIV/AIDS to own staff and those who can be immediately reached through the outreach programmes. Most of the partners have substantial reach – Government Ministries/ Departments, Public and Private sector in particular – through their vast number of employees, supply chain employees and the health & extension services they provide. These partners may be encouraged to mainstream HIV messaging in the existing mechanisms of information delivery.
- **Build capacities of key institutions at various levels** Capacity building and technical support are two key roles of NACO, SACS and developmental partners facilitating mainstreaming programmes. To this end, capacity building packages (videos, audio, online and set of trainers, positive speakers) will be developed and made available to mainstreaming partners. In addition, need based technical support to various partners will be provided in ensuring that the mainstreaming activities are rolled out successfully. Here, the support and partnership with Community Based Organisations and PLHIV and HRG are critical.
- **Mainstreaming for scaling up of HIV/AIDS services** Workplace programmes can raise awareness, support prevention, expand access to information and health services and prevent discrimination of workers infected or sick. Workplace has a vital role to play in the wider struggle to control the epidemic, as it affects workers and their families, enterprises and the communities which depend on them. HIV has negative effects amongst the workplace in terms of loss of income & benefit, loss of skills and experience, falling

productivity and reduced profit. Thus, HIV/AIDS needs to become a part of workplace health promotion policies. Discrimination and stigmatization against people living with HIV threaten fundamental principles and rights at work and undermine efforts for prevention and care.

- **Mainstreaming for Social Protection**

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

- Social Protection is designed to reduce poverty, inequality, vulnerability and multi-dimensional deprivation of specific population groups. Social Protection is a set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner); the provision of health care; and, the provision of benefits for families with children (ILO).
- The vulnerabilities related to job security, poor access to health care facility, low access to nutritional support and education for children etc. deteriorates the condition of the PLHIV. Studies have shown that stigma and discrimination related to HIV has diminished access of PLHIV to work and treatment minimizing the opportunities to earn and remain healthy. In this context, there is a need for creative responses to ensure PLHIV have access to many of these critical needs for their sustenance. Social Protection schemes play a crucial role to alleviate some of these challenges faced by PLHIV.
- Social Protection needs for the PLHIV and those affected are many – food security, nutritional security, health security, housing security, employment security, income security, life and accident security, and old age security. If Social Protection for PLHIV and those affected is appropriately designed, implemented and scaled up, it can protect them from shocks and allow them to reduce their extreme vulnerability; help them conserve and accumulate assets, promote their livelihoods; and transform their socio-economic relationships, to further improve their longer-term livelihood prospects.

- **Preventive schemes**

- Social Protection aimed at improving quality of life of PLHIV has been seen priority for the National AIDS Control Programme in India. National AIDS Control Organisation (NACO) through its mainstreaming has been making all efforts in this direction.

Preventive schemes focus on security and minimising risks. There are many schemes of the Government of India and of the State Governments), which are designed to protect marginalised groups like PLHIV and HRG from exposure to medical and their enterprise related risks.

Protective schemes focus on relief from deprivation through social assistance. These are designed to reduce vulnerability for the marginalised population.

Promotive Schemes aim at equity and poverty alleviation through livelihood programmes. Promotive schemes are designed in a way to lead to the capacity for self-protection. This is most difficult, yet extremely important task to achieve within the umbrella of Social Protection. These are oriented towards building capacities so as the marginalised can build their long-term livelihoods. The support provided by these schemes are related to legal aid, credit support, training, subsidy on capital assets, subsidy on starting production units for poultry, dairy etc.

Three-pronged strategy is suggested to deliver the Social Protection programme for PLHIV and HRG in India:

- **Modifications in existing schemes** To make PLHIV & HRG better eligible to seek the benefits, modification of schemes where possible should be facilitated. Some of the already existing Social Protection schemes can be modified to add special services or service provisions that are needed or relevant to PLHIV, besides the existing services (in the many schemes where it is necessary).
- **Exclusiveness** There are certain needs that are specific to PLHIV & HRG, which are linked to their survival. Specific needs such as treatment, nutritional support etc. Besides, sensitivity surrounding the infection makes it important to maintain confidentiality, requiring some of the essential schemes be exclusive and accessed through channels that will ensure stigma free environment and facilitate access.
- **Inclusiveness** Certain Social Protection schemes that already exist may not require any modification in the scheme provision but only to include the PLHIV & HRG in the list of beneficiaries. Reaching these communities with benefits of Social Protection schemes requires their access to mainstream programmes and schemes.

Some inclusive and exclusive schemes are operational in various States in India, which have high relevance for PLHIV and HRG. A detailed list of Central Ministries schemes is provided in Annexure.

To reiterate, NACP Phase-V was build on the systematised convergence with existing Central Government schemes, such as synergy with the National Health Programme, associated line Ministries, and State Governments, advocacy efforts to engage the political/ elected members through constituting/ reviving the Legislative Forum on AIDS and by mainstreaming and partnering to broaden the reach of various HIV-related services in a cost-neutral manner. Continued strategic engagement with the business sector is part of the NACP Phase-V collaboration framework. By 2025-26, the NACP Phase-V intends to cut annual new HIV infections and AIDS-related deaths by 80% compared to the baseline figure of 2010 (47%). While existing interventions will be preserved, refined, and strengthened under NACP Phase-V, innovative techniques will be adopted, piloted, and scaled-up to address geographic and community-specific requirements.

2. Background, Purpose of Manual & Learning Modules



The National AIDS & STD Control Programme envisaged to control the HIV epidemic at multiple levels in the country. Simultaneously, it addresses the Social Protection needs of the vulnerable/marginalized population to enhance the effectiveness of epidemic control programme. NACO, has come out with guidelines which insists the Social Protection interventions as part of the AIDS control programme across the country. It is visualised that, the Social Protection initiatives shall be integrated as one of the key components under targeted intervention programmes implemented at various levels with the support of TI Partners, ICTC, STI clinic, ARTC, DISHA, DAPCU, District Nodal Officer (HIV/AIDS). Simultaneously it addresses the Social Protection needs of the vulnerable/marginalised population to enhance the effectiveness of epidemic control programme. Vulnerable populations like People Living with HIV (PLHIV) and High Risk Groups (HRG) like Sex workers, Men Having Sex with Men (MSM), Transgender (TG), Migrant workers, etc. faces barriers in accessing the basic services like Health and welfare measures due to fear of stigma and discrimination and societal norms.

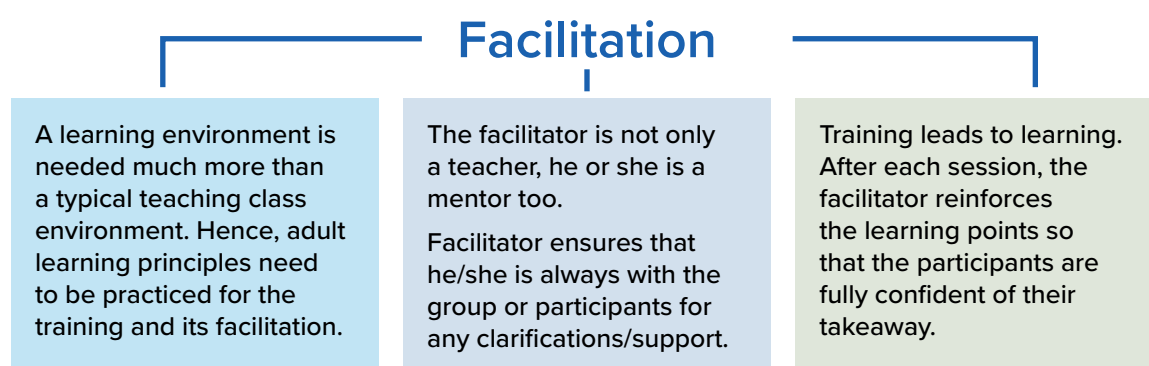
UNDP has been supporting National AIDS Control Organisation (NACO) on components like Mainstreaming and Social Protection. NACO conducted a capacity needs assessment of SACS Officials on Social Protection to strengthen the capacity gaps for effective implementation of Social Protection schemes. The assessment results highlighted that, there is a need for training on Social Protection. The training should address strengthen the skills to identify the issues, planning programmes and facilitation to access the Social Protection schemes. A strong request came from SACS officials to NACO is to provide appropriate training to SACS officials about Social Protection and Rights-Based Approaches to roll it out to reach PLHIV and HRGs. In continuation of this, the UNDP provided technical support to NACO in developing a training module to provide training to all the State AIDS Control Societies' key officials to initiate and integrate Social Protection interventions along with the HIV/AIDS interventions in the State. The strategy is to reduce the vulnerability among the communities intertwined in the programme by providing support to needy communities including HRG and PLHIV to have better access to the existing Social Protection schemes.

This training module developed covers components such as: Understanding Social Protection, Mainstreaming and its facilitation, Planning Social Protection Intervention for High Risk Groups, establishing partnerships, Resource mapping, categorisation, prioritisation and Public-Private partnerships, Stakeholder management and Advocacy for effective Social Protection interventions, Implementing Social Protection intervention for HRGs & PLHIV, Developing Social Protection intervention action plan for the State and more importantly identifying change indicators and integrating into existing reporting system, which is very critical for a successful programme implementation. This is a manual for facilitators who intend to train the key officials of SACS and other important stakeholders across the country. Modules are drafted and incorporated in the manual to train the officials on specific topics mentioned above.



3. The Learning Approach

There are many approaches to training. This could differ according to the subject of training and the people being trained. In this training programme the approach used is Adult Training Methods. In any training the expectation is that the participants learn something. So, a training programme should be done in a way that the participants will learn. No single training can provide all the capacities needed for being a good programme manager. The strategies for continuous capacity building need to be planned at state and district levels to sustain the quality of Social Protection initiatives integrated in the existing programme.



In any given situation, the following core principles need to be followed for any facilitation processes which aim on learning or skill development:

The facilitators need to understand that they have to follow a learning approach understanding the nature and functions of the officials participating in the programme.

Following points need to be incorporated in the facilitation processes while managing the sessions.

3.1

Each session needs to be handled in such a way that they realise that it is their responsibility to identify and manage the issues of the communities they work with

3.2

Use examples from project situations - e.g., what are obstacles they faced when doing community mobilisation, common issues faced while accessing Social Protection by the community etc.

Stories of such experiences will also be useful in understanding the issues and planning response systems. Examples of structural barriers and stigma needs to be discussed to understand the limitations of HRGs.

3.3

While discussing about components of TI as well as Social Protection needs to be addressed – use real practical situations to explain the concepts or related processes.

3.8

Intermittently ask the participants their opinion of what is being handled in the session – e.g., in resource mapping session, ask them what they think about the need for resource mapping, or some relevant question related to the expected output.

3.9

Usage of language and good vocabulary is very important in the facilitation process. Never use words which are not comfortable for the participants. Use empowering language. Ensure that, the trainees should take back memories of a pleasant experience after the training.

3.10

Providing comfortable learning environment is one of the key functions of facilitators. Give them friendly environment by always treating the participants with respect and friendliness.

Provide essential breaks. Never have coffee/ tea while the session is in progress – take a break when it is break time!

3.11

It is better that, the facilitator takes participants' opinion on all issues that come up in the training session. Always, compliment their correct knowledge and gently handle wrong perceptions by giving right answers.

3.12

It is always better to give compliments to the group rather than giving compliments individually. This will help to avoid interpersonal conflicts and individual inactiveness.

3.13

Whenever possible encourage the group to share their experiences regarding the relevant topic in the session.

3.14

Patient listening is an integral part of facilitation. Good listener can become a good facilitator. So, always be a good listener to the participants and understand what they want.

3.4.

When asking questions in a session, make sure that the first few questions are questions that they can easily answer. This may increase their confidence level and may lead to higher level of participation in the programme.

In any session, do not ask too many questions that they cannot answer which may demotivate them.

3.5.

During the initial facilitation process, try to identify their basic understanding about the training programme and its various topics. Build your session on what they already know.

If you find something is unacceptable to the participants, do not force it on them. Give more time. Bring it up sometime later in the session or some other session or maybe even the next day.

3.6.

Consider the participants' self-esteem as one of the key things to be protected during the training programme. Try to avoid telling things or doing things which may harm the self-esteem of the participants. Never say or do anything that could damage their self-esteem – it can be related to their exposure in TI management or management of other programmes in the state.

3.7.

There might be some sessions where too much of technical information must be shared. Keep such information giving sessions as short as possible (say 10 – 15 minutes). If more information needed to be given, bring in some interaction before going into the next 10 minutes.

4. Programme Schedule



2 Days Social Protection training for SACS officials

No	Time	Session name	Facilitator	Notes
DAY 1				
1.1	9.15 AM to 9.30 AM	Registration Pretest	Both the facilitators	<ul style="list-style-type: none"> Complete the registration in the prescribed format. The facilitators will execute the pretest questionnaire for 15 minutes
1.2	9.30 AM to 10.15 AM	Session 1 Introductory session Self-Introduction of participants Introduction to the programme Setting up of ground rules	Both the facilitators	<ul style="list-style-type: none"> Self-introduction shall be made by some ice breaking exercise. Why this programme 9.30 AM and its objective Involving the participants set up ground rules. Also select volunteers to do summing up for noon and afternoon sessions for the next day
1.3	10.15 AM to 11.15 AM	Session 2 - Need of Integrating Social Protection in HIV and AIDS responses	One facilitator	<ul style="list-style-type: none"> Understanding Social Protection and its importance in NACP Rights based approach and rationale of integrating Social Protection Ensuring sustained epidemic control through Social Protection intervention Exploring ways to integrate - steps to be followed 16
1.4	11.15 AM to 11.30 AM	Tea break		
1.5	11.30 AM to 12.30 PM	Session 3 - Steps 1 - understanding Social Protection, Mainstreaming and its facilitation	One facilitator	<ul style="list-style-type: none"> Conceptualisation and orienting state level team on Social Protection integration, Mainstreaming, multi-faceted and multi-sectoral approach How to set the team and monitor - team level and team to other levels

No	Time	Session name	Facilitator	Notes
1.6	12.30 PM to 1.30 PM	Session 4 - Step 2 - Planning Social Protection intervention for People infected and affected by HIV/ AIDS		<ul style="list-style-type: none"> ◆ Social Protection vulnerability mapping and needs assessment (need to do it separately for PLHIV and other High Risk Groups) ◆ Topography is also an important factor for hilly terrain and hard to reach areas. ◆ Ensuring Multiple levels of planning -PRI, ULB, District & State, TI Partners, ICTC, ARTC, DISHA/ DAPCU, STI Clinics, Care & Support Centres. ◆ Methods of information gathering from HRG and other key stakeholders ◆ Methods of analysis and using it for planning including vulnerability analysis ◆ Developing plans at multiple levels
1.7	1.30 PM to 2.15 PM	Lunch break		
1.8	2.30 PM to 3.30 PM	Session 5 - Step 3 - Establishing Partnerships Resource mapping, categorization, prioritization and Public Private Partnerships	One facilitator	<p>State, District, PRI, ULB and TI level mapping</p> <ul style="list-style-type: none"> ◆ Identify needs of facilitation in increasing the accessibility ◆ How to Facilitate the processes ◆ How to Ensure HRG access the schemes ◆ How to update resource map ◆ Integrating with the Social Protection plan ◆ Take into consideration community based structures (District and State Community Resource Groups, Community Champions, etc.) ◆ Establishing and managing public private partnerships ◆ Group discussion for 'Insurance Sector' for issue of Health Insurance Policy for PLHIV.
1.9	3.30 PM to 3.45 PM	Tea break		

No	Time	Session name	Facilitator	Notes
1.10	3.45 PM to 5.15 PM	Session 6 - Step 4 Stakeholder Management and Advocacy for effective Social Protection interventions	One facilitator	<ul style="list-style-type: none"> ◆ Identify key departments to work with and ensure to be part of the planning committee on schemes planning. Start with Dept. of Health and Dept. of Skill development. ◆ Identify existing gaps in Social Protection schemes and its accessibility ◆ Preparation of policy notes and plan integrating HRG felt needs - ensuring priority from departments. ◆ Planning for interdepartmental advocacy and stakeholder management systems ◆ How to roll it out ◆ How to sustain relations ◆ How to monitor the process and sustain the accountability ◆ Reporting systems for DAPCU and other service systems under SACS
1.11	5.30 PM to 6.00 PM	Summing up for the day	Both facilitators	Try to recap the key points learned.

DAY 2

2.1	9.30 AM to 11 AM	Session 7 - Step 5 - Implementing Social Protection intervention for HRG & PLHIV	One facilitator	<ul style="list-style-type: none"> ◆ Setting up district level support system and ensuring state level line departments' support ◆ Bringing role clarity of multiple level partners - SACS service providers including TI, HRG & PLHIV networks ◆ Ensuring development of service unit level action plans to roll programme - for both HRG & PLHIV ◆ Role of ART centers, TIs, ICTCs, STI clinics and other SACS supported units in Social Protection interventions. ◆ Monitoring and reporting
	11.00 AM to 11.15 AM	Tea break		

No	Time	Session name	Facilitator	Notes
2.2	11.15 AM to 12 noon	Session 8 - Developing Social Protection intervention action plan for the State -1	One facilitator	<ul style="list-style-type: none"> ◆ Need of a state level action plan for Social Protection interventions in the state. ◆ Key components of state level action plan ◆ Preparation of template for state level action plan ◆ Key consultations needed and involvement of key officials in preparing an action plan. ◆ Tips for action plan preparation
2.3	12.00 to 1.30 PM	Session 9 - Developing Social Protection intervention action plan for the State - 2 60 minutes for preparation of plan and 30 minutes for presentations	Two facilitators	<ul style="list-style-type: none"> ◆ Preparation of State level action plan by participants in group - based on the given templates ◆ Two groups will make presentations and it will be followed by discussions to finetune the plan
2.4	1.30 PM to 2.30 PM	Lunch break		
2.5	2.30 PM to 3.30 PM	Session 10 - Identifying change indicators and integrating into existing MIS	Two facilitators	<ul style="list-style-type: none"> ◆ Why documentation and monitoring ◆ Setting up IT enabled support to partner organisations - all the service providers and PLHIV networks ◆ Setting up performance and change indicators for Social Protection interventions at state level ◆ Planning of web portal giving information on all schemes and processes to access the same. ◆ Monitoring and documentation - integrating into existing MIS ◆ Developing best practices
2.6	3.30 PM to 4.15 PM	Summing up for the day And Post test	Two and facilitators	<ul style="list-style-type: none"> ◆ Fine tuning the plan course of action ◆ Valedictory
2.7	4.15 PM to 4.30 PM	Tea & break		



5. Approach to Facilitation

The specific role of the facilitator is to enable participants (key officials of SACS and other stakeholders) to develop their knowledge and understanding on issues related to planning, initiation and integration of Social Protection schemes into the HIV and AIDS responses in the state. In order to make it happen, the facilitator must provide useful information, guidance as per the reference materials. This training was designed to be delivered by facilitators who have previously viewed the training materials and who have experience in HIV and AIDS responses both at state and national levels.

Keynote for Facilitation

The present training is visualised in such a way that, the role of the facilitator is not just to pass on information, but to provide a learning environment in which participants can share their experiences and become comfortable with new ideas/information. Facilitated learning is based on the notion that people learn best in an atmosphere where they interact with others, are encouraged to ask questions, exchange ideas and feel supported by the facilitators.

Facilitators are encouraged to be creative in presenting the material. It is also important to select learning techniques appropriate for the audience and time frame. However, the facilitator is encouraged to adapt or change exercises to make them more relevant to situation. The facilitators are also encouraged to use energisers involving the participants on a need based manner without losing the tempo of the learning sessions.

Adult learning principles need to be adopted for implementing the module and the processes should be carried out in a learning environment rather than a classroom teaching environment.



5.1. Roles of Facilitators

1. In the self-introduction session, the facilitators should introduce themselves and give a brief about them. This will help the participants to keep up a positive approach towards the training programme.
2. Introduce each session with its topic name and rationale, if needed mention about the learning objective.
3. It is suggested to have two facilitators for each training programme - one lead facilitator and one co-facilitator. If needed more resource persons shall be invited for the programme and one among them may be from those who have started implementing Social Protection schemes effectively.
4. The facilitators shall sit together before the actual start of training programme and prepare themselves to conduct the programme. There should not be any confusion or contradictions among the resource persons while facilitating the sessions. NACO should allocate at least two days for the preparatory activities for the facilitators (it should be added to their TOR).
5. Before the planning session, the lead facilitators should go through the entire training module, reference materials and be familiar with each and every aspect of the programme concept, its planning and integration related guidelines.
6. The facilitators should be familiar with NACP, TI guidelines and its implementation, GIPA related programmes, reporting systems, core groups addressed by the TI and potential schemes available in the states.
7. An official from NACO shall support facilitators to conduct the programmes. The facilitators should also ensure with the NACO level or state level official that all the arrangements for the programme are completed well in advance.
8. The facilitators should give due respect to the participants and should respond to their queries and clarifications with due importance.
9. The facilitators should follow adult learning principles rather than a student learning approach.
10. Facilitators should use mix of local language and English or Hindi for all their communications, presentations and interactions in the programme.
11. All the facilitators should go through the manual thoroughly and make sure that before the programme itself the presentations are made ready.
12. The facilitator should encourage discussions among the participants and should handle the responses very sensitively and positively.
13. The facilitators should focus both on TI/GIPA programme-based service availability in the state as well as the Social Protection issues related to communities.
14. Please stick to the National AIDS Control Programme guidelines in briefing the programmes and service provisions.

15. Facilitators should use simple language during the sessions and be receptive when the participants request for clarifications.
16. Always prepare yourself to answer the questions of the participants. Do not bluff or give wrong information. If you do not know about a particular information, please say “do not know” and tell them the source where they can access the information, or you can refer some materials and give them the correct answer in the next session or next day.
17. The facilitator should always try to keep a link or continuity among sessions while implementing the module. It is better to give a brief on the session and how it linked to the previous one and the next one in the introductory part of the session.
18. The facilitator also visualises the programme as a learning platform. Always give patient listening to participants’ views and ideas related to the sessions and topics.
19. Be attentive and give due importance whenever participants respond to questions asked in the session. The participants should feel from your body language that they are given patient listening and due importance and recognition.
20. Try to avoid encouraging participants to verify or evaluate another participant’s answers or opinion; always tell them to supplement the other or support the other to make it better.

5.2. The Essential Qualities of Facilitators



1. **Good interpersonal communication:**

Communication plays an important role in managing a training programme. The facilitator needs to have good interpersonal communication skills which can be used for developing good relations with participants.

2. **Good understanding about the participants:**

The facilitator needs to have good knowledge and understanding about the participants - their background, how long they are involved with the programmes at state level, whether any initiatives done in this regard etc. So that facilitation will be more effective.

3. **Good organiser:**

The facilitator needs to be a good organiser which may help him or her to organise the programme in an effective manner. Good level of organising will increase the confidence level of the participants.

4. **Good rapport builder:**

Rapport building is one of key aspect in relationship development. The facilitator has to be good in rapport building so that sustainable relations will be maintained throughout the training programme.

5. **Good understanding of Social Protection needs and schemes:**

The facilitator needs to have good knowledge about the AIDS control programmes in the state as well as knowledge about Social Protection schemes available in the state. This will enable him or her to handle the sessions in a productive manner which will lead to a Social Protection intervention plan.

6. **Good understanding of NACO guidelines on mainstreaming:**

NACO guidelines are the key book for mainstreaming and Social Protection interventions for the state level managers. The facilitator needs to have good understanding of the same so that is more convenient for the participants to plan it accordingly.

7. **Good/Active listener:**

The facilitator should be a good listener with active listening skills, so that they will be able to give proper attention to the issues raised by the participants. Many participants may come out with many queries about planning of interventions, this has to be understood properly and supported.

8. Unbiased and non-judgmental:

The facilitator needs to have an open-minded approach where all are seen as equal. Whenever a group is addressed by the facilitator, it should be with an unbiased and non-judgmental approach. Facilitators should avoid prejudices while facilitating the programme.

9. Flexibility and adaptability:

A good facilitator must be able to adopt to changing circumstances and respond to the needs of learners. This includes adjusting the pace of the training, addressing unexpected questions, and modifying planned activities to suit the needs of the group.

10. Empathy and respect for learners:

A good facilitator must be empathetic to the needs of learners and create a safe and respectful learning environment. They should demonstrate cultural sensitivity and respect for diversity, and be able to create an inclusive learning environment for all learners.

5.3. Ethical Guidelines for Facilitation



Facilitator is a role model in all aspects. She/he is not just a technical support person, She/he is a person who has a professional approach and is person supportive without any bias. The facilitator needs to follow the ethical guidelines given below:

Social interaction

- Always respect people and do not get involved with the personal life of a person in the group whom you are facilitating.
- Be non-judgmental and approach the things with an open mind.
- Do not indulge in personal interactions while facilitating and do not involve into serious personal relations.
- The space for facilitation should not be used for personal gains as material benefits or sexual benefits.
- Do not involve into any of the official matters of the trainee and do not give any guidance other than the facilitation topics.
- Do not force or insist upon any trainee to do personal favors or personal things for you.
- Do not hurt the religious feelings of the trainees by making comments or doing any activity.
- Always do things based on your defined roles and topics you are handling.

Professional interactions

- Always follow the given guidelines in the learning modules and handbook.
- Strictly follow the adult learning principles and respect other people's knowledge and experience.
- Always start with a productive note by saying, if you do that, you may get this result.
- Do not insist others to do things but make them understand the need of doing things and support them to do it.
- Do not make comments on what they do or what they get by doing things. Provide productive feedback on processes and appreciate whenever good results are shown. Though result is not achieved, appreciate them for the efforts they have taken for the activities.
- Do not try to induce your ideas into others head, motivate them and give them opportunities to come out with ideas and do the things.
- Do not expect or accept any monetary benefits from any of the participants.
- Do not manipulate any data in the work environment and present it to any participants. Always ensure that correct data is used and related analysis is done.
- Do not create any situation where conflict of interest is reflected while doing facilitation.

Dress code

- Always wear socially acceptable dresses - it should be at par with social norms which prevail in the area. It is better for the facilitator to follow a simple and elegant dress code for the programme.

Non-discriminatory

- As a facilitator, you should not discriminate against any participant based on their race,
- gender, ethnicity, religion, or sexual orientation and PLHIV status. You should promote a safe and inclusive learning environment.

Things to be avoided

- Try to avoid instructing the participants to do the things. Always guide them by demonstrating things by doing it in a scientific manner as per the NACO guidelines.
- Try not to simply suggest things and keep away. Always be with participants even after suggesting the things. Try to provide hand holding support to complete the processes which they take up to achieve the outputs.
- Avoid making situation where conflicts take place. Always try to provide a conducive environment to the group so that they can think together, discuss the things, and plan the things in an effective manner.
- Do not take up activities which have conflict of interest in the content. Do not practice divide and rule in any of the training session which include group discussions.
- Avoid giving a wrong answer to any questions. If the facilitator is not aware of a fact, please refer to it with someone else and give the answers.



5.4. Don'ts for Facilitators

- ▶ Do not increase the speed in your communication. Always speak slowly and present the information point by point in a systematic way.
- ▶ Try to keep the time whenever sessions are handled and do not let the discussions go on for a long period. If it is a sensitive issue or has close links with specific state based issue, the facilitator shall allocate some time towards the end of the day for such discussions.
- ▶ Do not give false information or incorrect or uncertain information to the participants.
- ▶ Do not focus more on the technical aspects of schemes, rather focus on the accessibility issues and how to make them happen for the beneficiaries. Stick to the module and handle the sessions within the scope of the programme.
- ▶ Do not generalize things by projecting some individual incidents or single case information. Generalization needs to be done based on study results or practical evidence.
- ▶ Do not spend much time explaining the concepts like AIDS, HIV, Sex, Drugs etc.
- ▶ Do not ask sensitive questions to participants which may challenge their capacity or integrity or knowledge level or skills levels.
- ▶ Do not use mobile phones and laptops (other than presentation) in the programme hall during the secessions. If it is after the session or before the session, please go out and use it.
- ▶ Do not behave in a manner that is unfriendly and do not be careless about responses or being unresponsive generally.
- ▶ Do not bluntly tell people that they are wrong whenever such occasions arise - do it in a polished way to make sure that the confidence level of the participant is not affected.
- ▶ Do not give information and instructions that are too confusing or not related to the topic.
- ▶ Do not discuss things inappropriate to the situation or hurtful to individuals.
- ▶ Do not make participants feel self-conscious while giving examples - always use third party names.
- ▶ Do not deny opportunity for participants to share their knowledge and experience - always encourage the participants to do the same whenever it is needed or possible.
- ▶ Do not use vocabulary or terms that are difficult to understand or out of context.
- ▶ Don't monopolise the conversation: A facilitator's role is to guide the discussion, not dominate it. Be sure to encourage participation from all participants and give everyone an opportunity to speak.

- ▶ Don't forget to be inclusive: Ensure that all participants feel welcome and included, regardless of their background, experience or perspectives. Encourage open and respectful dialogue and address any instances of bias or discrimination.
- ▶ Don't rush through the material: Take the time to ensure that participants understand the content and have had the opportunity to ask questions. Rushing through the material can lead to confusion and a lack of engagement.
- ▶ Don't be rigid: Be flexible and willing to adjust your approach as needed. Be open to feedback from participants and be willing to make changes to the training as necessary.
- ▶ Do not use culturally insensitive words or examples.

PART

2

Learning Modules - Social Protection Interventions



6. The Learning Modules

How to use the learning modules

Before the start of the sessions, the facilitator should convey the following points to the participants and tell them that those things need to be reinforced while implementing each session in the module.

The trainees may have to do training of the state level intervention teams on a need-based manner, and it is always better to observe the facilitation processes taking place at intervention levels. Along with getting trained they should keenly observe the facilitation process and adopt it training of state level intervention teams.

Whatever knowledge they gain and whichever skills they develop during the training needs to be imparted to the intervention team on a need based manner. This will help the intervention team to improve themselves and implement the processes in an effective manner.

How to start the training

It is always better to start training by understanding the expectations of the participants and to give them an idea about the focus of the training programme. An exercise is given below to start training:

Exercise:

Why Are We Here? - Participants' Expectation and Expected Outcomes

Participants should be able to discuss what they intend to achieve at the training programme and what might hinder the achievement. They should state their expectations about the programme and how these expectations will be used as tools in HIV prevention by doing integration of Social Protection interventions. They may also share their concerns, if any, about the programme.

Methodology: Participatory discussion

Preparation/Material Required: Chart papers, markers.

Activity: Participants are given an opportunity to speak about their expectations for the training session and to state any concerns regarding planning of Social Protection interventions that they would like to initiate. Responses are recorded on a flip chart. Assess which expectations are likely to be met during the training workshop, and which ones may go beyond its scope. At the end of the session, a review of these initial expectations could be part of the evaluation.

The facilitator provides a brief explanation of the expectations of the training team for a successful training workshop incorporating participants' expectations. He or she explains what will happen during the training sessions in the next two days, so that participants are aware of what to expect.



6.1. Social Protection Intervention Planning – The Learning Modules

Overview of Day 1 Learning Module

1. Settings:

Classroom setting which has space for 35-40 participants and 2 facilitators. There should be space for the group exercises also. The facilities needed are white board, projector with laptop and screen and essential stationeries as per the learning processes requirement.

2. Registration:

The signatures of the participants need to be obtained in a prescribed format and a training kit will be provided to the participants.

3. Pre-test:

Pre-test has to be conducted in the given format and the facilitators need to analyze it and prepare for their facilitation.

4. Getting acquainted:

Use a game to introduce each and every participant to the group.

5. Introduction to the Programme:

The facilitators have to present and discuss about the objectives of the programme and give an overview of the 2 days programme.

6. Ground rule setting up:

Set up ground rules for keeping time, using mobiles, entertaining friends in the rooms and other group and individual interactions.

7. Session 1- 45 minutes:

Introductory session.

- 8. Session 2 - 60 minutes:**
Need of integrating Social Protection intervention
- 9. Session 3 - 60 minutes:**
Understanding Social Protection and Mainstreaming
- 10. Session 4 - 60 minutes:**
Planning Social Protection intervention
- 11. Session 5 - 60 minutes:**
Establishing Partnership & Resource listing
- 12. Session 6 - 90 minutes:**
Stakeholder Management and Advocacy
- 13. 30 minutes:**
Summing up of the day

6.1.1. Session 1 - Introductory Session



Session 1 - Introductory Session

Introduction of participants and facilitators Introduction to the programme and setting up of ground rule pre-test.

Key methodologies:

Self-introductions, Group games

Duration of session:

45 minutes

Materials to be used:

White board and markers, Presentation materials

Learning objectives:

To orient the participants about the objectives of training programme and its expected outcomes

Assumptions:

'This Is an opportunity for all the participants to get acquainted with each other and to understand the objectives of the programme

Learning processes:

- Welcome the group
- Pair the participants and give them some time to discuss amongst themselves and let them introduce each other in front of the group. Facilitator is also involved in the exercise
- The facilitator will give an introduction about the starting of the programme for 5 to 10 minutes
- If needed the facilitator can ask about the present understanding of participants about the programme - 5 to 10 minutes
- Following the introduction, the facilitator will make a presentation on the programme for 10 minutes.
- The last 20 minutes will be kept for clarifications basically on the functions of the programme. 'The need of a sensible approach to be stressed and explained to the participants with clarity. Do pre-test using questionnaire.

6.1.2. Session 2 - Need of Integrating Social Protection Interventions



Session 2 - Need of integrating Social Protection Interventions in HIV/AIDS responses

Key points to be covered:

Understanding social protection and its importance in nacp, rights based approach and rationale of integrating social protection in hiv/aids responses, ensuring sustained epidemic control through social protection intervention, exploring ways to integrate.

Key methodologies:

Presentation, Discussions

Duration of session:

45 minutes

Materials to be used:

White board and markers, Presentation materials

Learning objectives:

To orient the participants about the importance of Social Protection interventions in HIV responses and how effectively epidemic control shall be obtained through Rights Based Approach

Assumptions:

The participants listen to the presentation and they come out with more questions with regard to Rights Based Approach and its relevance in HIV/AIDS responses

Since it is the first session, there is a possibility that, the participants may show little rigidity in listening to the concepts. They may not be that flexible in adjusting with the learning procedures

Learning processes:

- As an introductory remark, tell the group that, they all are in the programme for so many years and also have good experience in managing the programmes and various stakeholders for epidemic control.
- Ask them what is their understanding about Social Protection, Rights Based Approach, scope of integration in HIV responses - write down these three concepts on the white board and encourage the participants to come out with their points. List down the points under each heading. If they come out with some wrong points, clarify the mismatches. Encourage discussions and slowly move on to your presentation.
- The facilitator may take about 20 minutes for the introductory exercise.
- Next 30 minutes the facilitator will do the presentation explaining the concepts of Rights Based Approach, Social Protection and need of integrated approach.
- Use few examples from the field - which are proven experiences in various states related to both PLHIV and other primary stakeholders of Targeted Interventions -to explain the concepts.
- The last 10 minutes shall be kept for clarifications basically on the interrelations between epidemic, its socio-economic impact and how much the groups are struggling to cope with the situations.
- Towards the end the facilitator will share his views on the ways working with various departments and agencies in ensuring quality of Social Protection interventions.
- Before closing the session, tell the participants that in the next sessions we are going to discuss in detail about the various steps to set up Social Protection interventions in HIV/AIDS responses

Note: Please refer to Reference material section page No. 65

6.1.3. Session 3 - 1 Understanding Social Protection and Mainstreaming



Session 3 - Step 1 - Understanding Social Protection interventions, Mainstreaming and its facilitation

Key points to be covered:

Understand the definitions and essence of Social Protection interventions – what and how, Mainstreaming and the need of Multi-sectoral Approach Setting teams, and Planning for monitoring

Key methodologies:

Presentation
Group work
Group presentations and
Case studies

Duration of session:

60 minutes

Materials to be used:

White board and markers
Chart paper and permanent markers
Presentation materials

Learning objectives:

To make the participants understand about the interrelations of Social Protection intervention and Mainstreaming adopting Multi-sectoral approach

Assumptions:

The participants are aware of Mainstreaming initiatives as part of the NACP carried out in concerned states

Learning processes:

- This session has to be conducted as a review session. Review of what they have done at their end as part of mainstreaming initiatives.
- They also should be encouraged to share the strengths and weakness of those programmes which they introduced as part of mainstreaming. If there are some failures let them come out with the factors influenced the same.
- Pick out the factors influenced the failures or contributed to the success and explain how it contributed to strengthen the HIV responses.
- Identify two volunteers who are willing to talk about mainstreaming, Social Protection intervention and planning multi-sectoral approach. Encourage them to share their experience about the concepts and practice – how they planned their mainstreaming activities and ensured multi-sectoral support.
- Let them also talk about the achievements and how it effectively contributed to the epidemic control (their perception).
- Let it continue for 20 minutes. While the volunteers make their presentation, the facilitators have to write down the strengths and weaknesses of points the volunteers presented.
- Identify key points from the presentations and discuss how to learn from those experiences and plan better for an effective Social Protection initiative.
- Give a brief on the same for 10 minutes and start the presentation.
- Make the presentation which consists of slides on essential team and setting up monitoring systems for 20 minutes and keep 10 minutes for clarifications.

* Note: Please refer to Reference material section page No. 70

6.1.4. Session 4 - Planning Social Protection Intervention



Session 4 - Step 2 - Planning Social Protection intervention for People living with and affected by HIV/AIDS

Key points to be covered:

Social Protection Vulnerability Mapping and Needs Assessment – for People living with and affected by HIV/AIDS

Ensuring multiple levels of planning – TI and Positive network levels, ICTC, ART, STI clinics and VIHAN CSC.

Methods of information gathering from People living with and affected by HIV/AIDS

Vulnerability analysis

Developing plans – multiple levels – How to plan

Key methodologies:

Group exercises

Discussions

Presentation

Duration of session:

60 minutes

Materials to be used:

White board and markers

Chart paper and permanent markers

Presentation materials

Learning objectives:

To make the participants understand the need of vulnerability analysis and needs assessment and the different ways of planning for Social Protection

Assumptions:

It is assumed that the participants are aware of vulnerability analysis and needs assessment as part of TI programmes.

They might be using the same techniques for vulnerability and needs assessment aiming social situations.

Learning processes:

- Do a presentation for 10 minutes clarifying the present vulnerability and needs assessment in the TI programmes. Link it with the Social Protection aspects and brief them on how it enhances the vulnerability factors of High-Risk Groups and PLHIV.
- Brief them about the social aspects which need to be looked into. It includes the availability of Social Protection schemes with various department and the accessibility for High Risk Groups.
- Ask them about the determining factors influencing the accessibility of these schemes and list it down. It might be the awareness of HRG, no one to facilitate, unfair practices at government offices, proximity of offices, or their own lethargy, etc. Pick out each point and discuss in detail and ask the group, how to address the same.
- Divide the group into 4 or 5 and give them 30 minutes to develop a plan for any of the High Risk Groups or PLHIV to address one issue and make them access to Social Protection schemes
- Let the group discuss it for 30 minutes and come out with a presentation.
- Once the presentations are ready, let them present it one by one. Encourage discussions after each presentation
- Give concluding remarks insisting about the need of vulnerability and needs assessment and group based planning.

* Note: Please refer to Reference material section page No. 81

6.1.5. Session 5 - Establishing Partnerships



Session 5 - Step 3 - Establishing Partnerships - Resource mapping, categorisation, prioritisation and exploring Public Private Partnerships

Key points to be covered:

Need of State, District and PRI and ULB level resource mapping (Various Schemes available) by -TIs and PLHIV networks and community based structures. (District and State Community Resource Groups, Community Champions, etc.)

Feasibility assessment and prioritisation of schemes - for TI HRGs and PLHIV

Identify key areas of facilitation to increase the accessibility to schemes for HRGs and PLHIV

Develop plan and indicators to ensure that HRGs/PLHIV access the schemes

Explore the possibilities of public private partnerships in accessing schemes and other resources

Key methodologies:

Presentations

Open group discussions about available schemes and linking it to resource mapping

Role plays

Duration of session:

60 minutes

Materials to be used:

White board and markers

Chart paper and permanent markers

Presentation materials

Learning objectives:

To orient the participants about the need and various ways to do resource mapping and its analysis for prioritization

To make the participants understand about the need to public private partnership and its benefits

Assumptions:

The participants have some understanding about the Social Protection schemes available with various departments. The participants are open for public private partnerships

Learning processes:

- First make a 10 minute presentation on the needs of resource mapping, analysis and prioritisation – individual and groups.
- After that go for an open discussion with participants and ask them the schemes which know about for marginalised groups – encourage the participants to come out with various schemes which they know.
- List down all the schemes and whom they are meant for and with which department it is available, formalities to complete to access the same and link it with the resource mapping format. It should include the public and private sectors
- Analyse the schemes by sorting them based on the suitability to our HRGs and PLHIV – it may lead to prioritization
- Ask the group – according to them where exactly the HRGs/PLHIV need facilitation to access the same and why? Address the barriers and stigma while accessing the schemes.
- Write down all the views against each scheme and assess the feasibility
- Role play – Invite three volunteers – One is a government servant managing a scheme and one is a HRG and one is a facilitator. The HRG along with facilitator go to the government servant and try to get access to the scheme. The government servant can show possible ways of resistance and the HRG can exhibit the helplessness and facilitator shall show the various ways to intervene and get access to the scheme for HRG
- Make concluding remarks based on the situation presented and link it to your first presentation. (Suggestive priority schemes for HRGs/PLHIV may be presented by Facilitator)

* Note: Please refer to Reference material section page No. 82

6.1.6. Session 6 - Stakeholder Management and Advocacy



Session 4 - Step 4 - Stakeholder Management and Advocacy for effective Social Protection interventions

Key points to be covered:

Listing of key departments to work with. Identify key departments to work with and ensure to be part of the planning committee on schemes planning. Start with Dept. of Health and Dept. of Skill development.

Identify existing gaps in interdepartmental collaboration.

Listing suitability of schemes for HRGs/PLHIV. Share links of other states best practices schemes.

Planning advocacy with other departments and potential private resource agencies/ individuals

How to rollout the plan and with which machinery - TIs & PLHIV groups

Ensuring DAPCU and SACS support at State and District levels

Key methodologies:

Group discussions

Presentations

Duration of session:

90 minutes

Materials to be used:

White board and markers

Chart paper and permanent markers

Presentation materials

Learning objectives:

To make the participants understand about the need of collaborative initiatives and how to plan and carry out advocacy with line departments and private organisations

Assumptions:

The participants have exposure in inter departmental collaboration and earlier they organised some meetings to discuss about collaboration

They also understand the concept of advocacy and aware of TI level and PLHIV network level advocacies carried out

Learning processes:

- Start with a brief introduction about the need of interdepartmental collaboration and explain them presently how we are doing it. Also tell them that we may have to identify whether there are any gaps.
- Divide the group into 4 and ask them to list down the present status of collaboration with line departments, how often they do that, in which way they do that (over phone or specific meetings or meeting them in some other occasions etc.), who is doing that and what outcome they get out of that - make it for 20 minutes
- Let them make presentation for 10 minutes and identify the gaps in the present way doing things
- After the presentation, let the group sit once again for 30 minutes and work on an advocacy plan with line departments as well as for the private resource agencies with potential agencies and departments, frequency, which level, with what objective, follow up plans, needed support at state & district levels and success indicators
- After the group discussions, let them present it one by one in the given chart papers and discuss about the same.
- Conclude it with insisting upon the need of preparing such advocacy plans and execute it periodically to keep the relations and ensuring the support from departments and other agencies. (Suggestive effective mechanism for stakeholder management & advocacy may be 'presented by Facilitator)

* Note: Please refer to Reference material section page No. 85

Once the sessions are over, do a summing up of the day- go to each session and ask them what the takeaway are and how it is linked to planning and implementation of Social Protection intervention for HRGs and PLHIV

If possible, please give a brief about tomorrows sessions so that the participants will be able to mentally prepared for the same

1. Settings:

Classroom setting which has space for 35-40 participants and 2 facilitators. There should be space for the group exercises also. The facilities needed are white board, projector with laptop and screen and essential stationeries as per the learning processes requirement.

2. Energisers:

Need based energisers have to be planned in between the session with the support of the participants

3. Session 7- 90 minutes:

Implementing Social Protection intervention for communities

4. Session 8 - 45 minutes:

Action plan development - introduction

5. Session 9 - 90 minutes:

Action plan development - group exercise

6. Session 10 - 60 minutes:

Identifying change indicators and integrating into existing MIS

7. Summing up for the day:

Discuss about the key points learned in the day and their takeaway of the training

6.1.7. Session 7- Implementing Social Protection Intervention for HRGs and PLHIV



Session 7 - Step 5 - Implementing Social Protection Intervention for HRGs and PLHIV

Key points to be covered:

Bringing role clarity in carrying out Social Protection interventions by multiple partners – SACS, DAPCU, TI, PLHIV networks, ART centers, ICTC & STI Clinics

Setting up/strengthening support systems at district level to support the service providers in rolling out intervention

Ensuring service unit level action plans to roll out the programme - both for HRGs and PLHIV

Monitoring and reporting for service provided

*(Role clarity of technical person from each dept. in data feeding, data analysis, reporting is needed.)

Reporting indicators need to be added in existing MIS. MLL etc.

Social Protection indicators & updated information needs to be added in MLL (also in Vihaan data & TI form A) such as current age, educational status, Aadhar Card, Ration Card, Voter card, TG card, TB, orphan status etc. So that eligibility for different schemes can be easily available at the state level & the target for each scheme will be decided for the SACS. If someone takes transfer to another state, expires etc. then reason for not availing the schemes will be there & accordingly target will be changed.)

Key methodologies:

Case study and group work

Group discussions

Presentation

Duration of session:

90 minutes

Materials to be used:

White board and markers

Chart paper and permanent markers

Presentation materials

Learning objectives:

To make the participants understand about the roles and responsibilities of various stakeholders and service units in providing Social Protection intervention support to various primary stakeholders

The participants get a chance to brainstorm about the support needed at different levels and reporting requirements.

Assumptions:

There is possibility that the participants' may get clarity on each one's roles in intervention and how to share their responsibility. This will evolve from the case study discussions and following group work

Learning processes:

- Prepare two case studies of need of Social Protection schemes for the HRG and PLHIV and specify the following things in the case study - The socio-economic condition, how it increases the vulnerability, schemes available for the issue, determinants of non-accessibility, and how to ensure the accessibility.
- Divide the group into 4 and give them 40 minutes to make a plan to address the issue. Two groups will handle FSW issue, and 2 groups will handle PLHIV In that they have to specifically describe roles and responsibilities of various agencies - SACS, DAPCU, TI, PLHIV network, STI Clinics and other service units. They also work out the support systems at local, district and state levels
- After that each group will make presentations and it will be followed by discussions - 30 minutes
- Towards the end the facilitator will make a presentation and specify the roles, responsibilities, and support systems. He will also give a brief on the need and systems for monitoring and reporting - 20 minutes.

* Note: Please refer to Reference material section page No. 87



6.1.8. Session 8 - Action Plan Development - Introduction

Session 8 - Developing Social Protection intervention action plan for the State - part 1

Key points to be covered:

- Need of a state level action plan for Social Protection interventions in the State
- Key components of State level action plan
- Preparation of template for State level action plan
- Key consultations needed and involvement of key officials in preparing an action plan
- Tips for action plan preparation

Key methodologies:

Presentation
Group discussions

Duration of session:

45 minutes

Materials to be used:

White board and markers
Presentation materials

Learning objectives:

To make the participants understand about the need of a state level action plan for Social Protection interventions at multiple levels through service units

Participants understand about the components and consultation processes involved in developing the state level action plan

Assumptions:

Participants recollects the steps discussed in setting up Social Protection intervention at different levels and uses the same in developing an action plan

Learning processes:

- As an introduction, the facilitator takes the participants on a tour referring the previous sessions which focused on the steps in setting up Social Protection intervention
- Then the facilitator makes a presentation on the need of state level action plan, key components need to be reflected in the action plan and processes to be completed in preparing the action
- This will be followed by open discussions and encourage all the participants with their doubts
- Clarify each of their doubts with examples from the field and tell them about the possibilities of failures even if everything is perfectly carried out. This might be because of the unpredictable conditions like natural disasters or change in the leadership or change of perceptions among the primary stakeholders
- Conclude the session with a lead to the next session which involves active group work and the relevance of developing an action plan

* Note: Please refer to Reference material section page No. 91



6.1.9. Session 9 - Action Plan Development - Group Exercise

Session 9 - Developing Social Protection intervention action plan for the state - part 2

Key points to be covered:

Preparation of action plan by participants in group - based on the given template
Three states plan will be developed in groups as an exercise

Key methodologies:

Group work
Presentation
Discussions

Duration of session:

90 minutes

Materials to be used:

White board and markers
Chart papers and permanent markers
Presentation materials

Learning objectives:

To develop skills of participants in preparing the action plan for Social Protection intervention at state level

Assumptions:

The participants in group discuss and prepare the action plan based on the inputs they received in the earlier sessions

Learning processes:

- Give an introduction about the plan development and how to do that based on last session presentation - 10 minutes
- Divide the group into 3 and tell them to make a state level action plan for rolling out Social Protection intervention based on the given template - 30 minutes
- Once they are through with the exercise let them present the plans in a common platform and discuss and fine tune the same with the inputs of the participants - 45 minutes
- Use the rest of the time for concluding remarks and lead them to the next session



6.1.10. Session 10 - Identifying change indicators and integrating into existing MIS systems

Session 10 - Identifying change indicators and integrating into existing MIS systems.

Key points to be covered:

- Why documentation and monitoring
- Setting up IT enabled support to partner Organisations - all the service providers and PLHIV networks
- Setting up performance and change indicators for Social Protection interventions at state level
- Planning web portal giving information on all schemes and processes to access the same
- Monitoring and documentation - integrating into existing MIS
- Developing best practices

Key methodologies:

Presentation
Discussions

Duration of session:

60 minutes

Materials to be used:

White board and markers
Chart papers and permanent markers
Presentation materials

Learning objectives:

To make the participants understand the need of documentation and reporting and explore the possibilities of integrating into the existing MIS systems

Assumptions:

The participants have a minimum knowledge about the existing MIS with regard to various components of National AIDS Control Programme

Learning processes:

- Make a brief presentation on expected needs of documentation and identifying change indicators with regard to Social Protection intervention.
- Divide the group into 4 and tell them to list down the reporting requirements with regard to the intervention and identify the various provisions within the existing MIS to incorporate the programme reporting.
- After the discussion, let any two group present this and go for an open discussion about the same.
- If it is possible this shall be discussed with a MIS person either in person or on line and get his feedback on the same for the participants.
- The MIS expert can share his views on integrating the reporting requirements into the existing MIS systems.
- Conclude the session with a note on insisting proper documentation of the programme while implementing it - the data needs to be pooled from each service unit level.

* Note: Please refer to Reference material section page No. 92

Once the sessions are over, do a summing up of the day- go to each session and ask them what are the takeaway and how it is linked to planning and implementation of Social Protection intervention for HRGs and PLHIV

As a second step give them the post-test questionnaire and get it filled and collected.

Pre-test and Post-test Questionnaire - Social Protection Intervention Training



Pretest questionnaire for 3 days' induction training programme on Social Protection intervention		The participants have to put a tick mark (✓) in the appropriate columns based on their understanding			
No	Topic	Very good	Good	Average	poor
1	Knowledge on Social protection schemes				
2	Clarity on NACP				
3	Clarity on the concept on TI				
4	Clarity on PLHIV/GIPA				
5	Clarity on roles of each stakeholder				
6	Understanding one resource mapping				
7	Understanding on public private partnership				
8	Understanding on vulnerability mapping				
9	Understanding on Social Protection intervention planning				
10	Understanding on advocacy				
11	Understanding on establishing partnership and its maintenance				
12	Understanding on Social Protection intervention rolling out				
13	Clarity on reporting and monitoring of Social Protection interventions				

PART

3

**Social Protection
Intervention
Training Reference
Materials**

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1. Overview of NACP Phase -V (2021-26)

NACP Phase-V is a Central Sector Scheme, fully funded by the Government of India, with an outlay of Rs 15471.94 crore. The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The NACP Phase-V also aims to attain dual elimination of vertical transmission, elimination of HIV/AIDS related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations.

1.1. The specific objectives of the NACP Phase-V are as below:

HIV/AIDS prevention and control

- 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention.
- 95% of HIV positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load.
- 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV.
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.

STI/RTI prevention and control

- Universal access to quality STI/RTI services to at-risk and vulnerable populations.
- Attainment of elimination of vertical transmission of syphilis.

Under NACP Phase-V, while the existing interventions will be sustained, optimized, and augmented; newer strategies will be adopted, piloted, and scaled-up under the programme to respond to the geographic and community specific needs and priorities. The HIV and AIDS (Prevention and Control) Act, 2017 will continue to be the cornerstone of the national response to HIV and STI epidemic in NACP Phase-V. The Act will be the enabling framework to break down barriers driving delivery of a comprehensive package of services in an ecosystem free of stigma and discrimination.



1.2. Guiding Principles of NACP Phase-V (2021-26)

Eight guiding principles will be central to strategies and activities to attain the specific targets.

1. Keep beneficiary and community in center.
2. Break the silos, build synergies.
3. Augment strategic information-driven planning, implementation, monitoring, and mid-course corrections.
4. Prioritise and optimise through high-impact programme management and review.
5. Leverage technology and innovation as critical enablers.
6. Enhance and harness partnership.
7. Integrate gender-sensitive response.
8. Continue fostering technical arrangements and institutions.

NACP Phase-V will build upon the systematised convergence with the existing schemes of Central Government including synergy with National health programme, related line Ministries as well as State Governments through mainstreaming and partnership extending the reach of various HIV related services in a cost-neutral way. The collaboration framework of NACP Phase-V includes continued strategic engagement with private sector.

1.3. Goal 1: Reduce annual new HIV infections by 80%

NACP Phase-V will accelerate reduction in new annual HIV infections through a basket of strategies tailored to the high-risk, at-risk, and low-risk population groups.

- Continue and evolve the existing peer-led targeted interventions (TI) and Link Worker Schemes (LWS) strategies for integrated services.
- Promote evidence-backed comprehensive prevention packages tailored to location and population.
- Strengthen the population size estimation and field epidemiological intelligence for coverage expansion and saturation.
- Expand and intensify the coverage of NACP interventions including OST among Injecting Drug Users (IDU).
- Universalize the NACP interventions in prisons and other closed settings through a mix of service delivery models.
- Pilot and scale models for community-based integrated service delivery models.
- Redefine and expand coverage among the bridge population.
- Develop and roll-out new generation communication strategy suitable to current context.
- Cover 'at-risk' HIV negative through comprehensive prevention packages to keep them negatives.

- Develop and scale-up sustainable models for 'at-risk' Virtual Population.
- Maintain and augment the behavior change communications for general population.
- Sustain focus on adolescent and youth population.

1.4. Goal 2: Reduce AIDS-related mortalities by 80%

NACP Phase-V will build upon the strong momentum from previous phases and further accelerate the reductions on AIDS-related mortalities through strategies directed across care continuum.

- Maintain the existing models of HIV counselling and testing services (HCTS) and expand through strategic scale-up.
- Develop and roll-out tailored communication campaigns focusing on risk perception and HCTS uptake.
- Augment the existing HCTS models with efficient approaches for active case findings promoting early detections.
- Appropriately adapt evidence-backed newer technologies to supplement existing models.
- Maintain existing care, support, and treatment (CST) services models and expand further through sustainable manner.
- Continue provisions of high-quality ARVs through differentiated service delivery models improving through sustainable manner.
- Focus on rapid ART initiation and advanced HIV disease management augmenting quality of care.
- Suitably update the treatment guidelines periodically.
- Address linkage loss at all levels.
- Optimise the uses of public sector laboratories for viral load measurements.
- Offer integrated service delivery packages to 'at-risk people' and PLHIV.
- Prioritise sexual and reproductive health services for women at increased risk of HIV infection and women living with HIV.
- Bring efficiencies and improve linkages through single window service delivery models.
- Maintain and expand laboratory quality assurance system.

1.5. Goal 3: Eliminate vertical transmission of HIV and Syphilis

The NACP Phase-V takes into the account the global guidance towards elimination of vertical transmission of HIV and Syphilis.

- Augment comprehensive synergy with NHM for testing of pregnant women for HIV and syphilis.
- Strengthen the primary prevention through coordinated actions.
- Introduce and scale-up dual test kits (HIV & Syphilis) to fast-track progress on the dual elimination.
- Strengthen linkage from screening facilities to confirmatory centers and subsequently to the treatment centers.

- Strengthen retention and on-ART adherence among eligible WLHIV.
- Prioritize family planning services for eligible PLHIV.
- Strengthen the early diagnosis of infants and all children living with HIV (CLHIV).
- Engage with private sector augmenting their role in attainment of dual elimination.
- Strengthen the strategic information in the context of HIV positive pregnant women/mother.
- Prepare strategic roadmap to guide actions towards attainment of validation of elimination of vertical transmission.

1.6. Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable populations

NACP Phase-V will reinforce the STI/RTI component not only in terms of elimination of vertical transmission of HIV and syphilis but also to augment access to quality STI/RTI services through maximizing its system and opportunities for shared delivery models.

- Strengthen the strategic information on STIs.
- Maintain the existing model of Designated STI/RTI Clinics (DSRCs) augmenting the role.
- Develop and implement integrated communication strategies.
- Dovetail dual testing at HCTS centers.
- Promote active case findings facilitating early detections.
- Improve collaboration with NHM on STI/RTI services provisions and reporting.
- Strengthen and streamline private sector engagement on STI/RTI management.
- Suitably update the STI/RTI management guidelines periodically.
- Augment the laboratory capacities.
- Strengthen the supply chain management.

1.7. Goal 5: Eliminate HIV/AIDS related stigma and discrimination

NACP Phase-V will build upon the gamechanger initiatives of NACP-Phase IV (Extension) to accelerate the progress on elimination of HIV/AIDS related stigma and discrimination.

- Undertake bottom-up institutionalized community system strengthening.
- Accelerate the notification of State rules and appointment of Ombudsman in the context of the HIV and AIDS (Prevention and Control) Act, 2017.
- Undertake sensitisation of related stakeholders on HIV/AIDS related stigma and discrimination.
- Design and implement communication strategy on elimination of HIV/AIDS related stigma and discrimination.
- Enhance strategic information on HIV/AIDS related stigma and discrimination.
- Engage with State governments promoting launch and scale-up of Social Protection schemes.



2. Rights Based Approaches to Social Protection

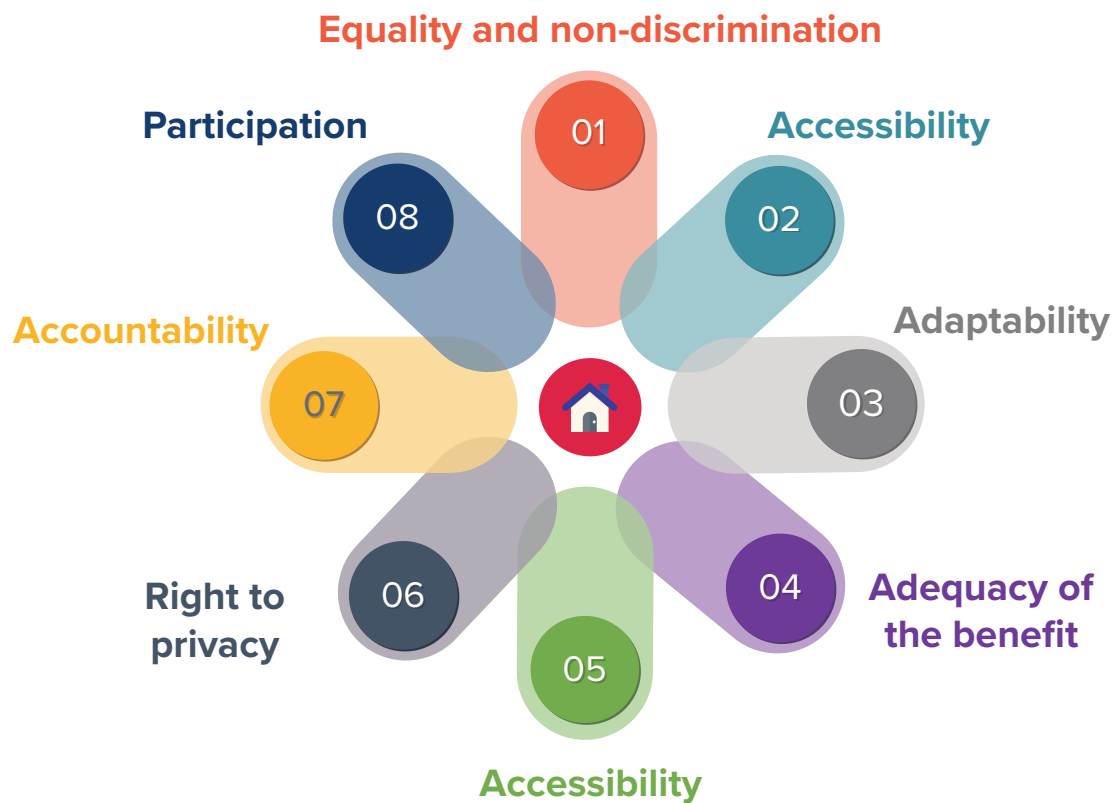
There is a strong congruence between a Rights-Based Approach and Social Protection. If designed in a rights-based manner, SP policies and instruments can contribute to the better realisation of the rights of the vulnerable.

There are a number of ways in which a RBA can contribute to the justification, design, implementation and monitoring of SP. The key contributions are summarised below. A RBA:

- ▶ Considers SP to be a right and entitlement, and not just a matter of charity. Beneficiaries of SP schemes are seen as 'rights-holders, making legitimate claims on the allocation of resources and availability of services.
- ▶ Identifies a set of minimum state obligations in particular in relation to economic, social and cultural rights, including an adequate standard of living, which implies a focus on the provision of at least minimum levels of social services, and a focus on equal accessibility to these goods and services. Poorer nations' limited resources imply that international assistance may be required to meet these obligations, in addition to improved domestic prioritisation and resource management.
- ▶ Recognises that there is a human right to social security, which requires states to develop appropriate policies and programmes, aiming to meet the minimum standards set in particular by the ILO.
- ▶ But more importantly can use the full range of international human rights standards to justify SP and inform policy development and programming - this includes civil and political rights which can play more than an instrumental role in realising other rights associated with SP.
- ▶ Guarantees special protection to vulnerable groups based on identity or life-cycle stages, for example child protection against domestic or institutional violence, or exclusion from services based on race or gender.
- ▶ Provides a set of principles, which both justifies SP and can be used to assess and select SP instruments. The principles of inclusion, equality and non-discrimination are central both to a RBA and to SP and focus attention on the most vulnerable. Participation and accountability are also required to realise rights and inform the design of SP instruments and the broader social and political contexts within which they operate.
- ▶ Recognises the importance of citizenship as a justification for SP and a mechanism to ensure that rights are specified into claimable, concrete entitlements. This also draws attention to the various political incentives associated with various SP schemes, which can solidify citizenship bonds or further patron-client relations as a result of the degree of discretion or their informality. Non-citizens are, however, also entitled to some forms of SP, and equal citizenship may need to be extended in practice (e.g., to minorities, women).

- ▶ can be applied through various channels of contestation and accountability. This includes both demand-side actions to claim rights (e.g., empowerment, social movements) and supply-side reforms to guarantee the delivery of rights (e.g., public service and expenditure management reforms). Access to justice is one channel through which rights can be claimed and enforced and the state held to account.
- ▶ focuses on building the capabilities of actors and institutions. It is not a model based on a passive provision of benefits or transfer of resources, but one requiring the progressive building of sustainable structures and capabilities of individuals and groups to be aware of rights and entitlements, claim them or deliver them.

Human rights standards & principles for the design and implementation of SP programmes



Source: Development Pathways. Human Rights Based Approach to Social Protection, narratives around Poverty and Policy Implications. Alexandra Barrantes, Senior Social Policy Specialist.

3. Mainstreaming



Mainstreaming is a process which enables government, public/private sector businesses and civil society organisations to address issues of HIV and AIDS in a sustained manner, through their usual work. It is a strategy to operationalize multi-sectoral responses.

Mainstreaming involves growing organisational consciousness and culture towards addressing HIV both within the organisation (internal) and as part of the field level activities of the organisation (external). This requires persistent advocacy with the key decision makers to build commitment at the highest level.

3.1. Definition and types of mainstreaming

Mainstreaming HIV is a process that enables developmental actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work within their workplace. It implies that the sector determines how the epidemic is likely to affect the sector's goals, objectives and programmes and where the sector has a comparative advantage to respond to and limit the spread of HIV and to mitigate the impact of the epidemic. The process of mainstreaming can be classified into two main categories which are not mutually exclusive.

Internal Mainstreaming is about adapting organisational policy and practice in order to reduce the organisation's susceptibility to HIV infection and its vulnerability to the impacts of AIDS. The focus is on the internal staff and includes:

- Development and implementation of a workplace policy
- Training/sensitization of all staff within the office/workplace
- Provision of services related to prevention, care and treatment for staff members..

External Mainstreaming refers to adapting the organisational core programmes or work in order to take into account the reality of HIV and AIDS. This aspect of mainstreaming seeks to strengthen the organisation's core business without changing the focus on health care. This may entail:

- Identification of entry points where HIV could be mainstreamed into the ongoing work of the organisation
- Training and sensitisation of the outreach workers/staff of the organisation
- Inclusion of HIV in the detailed programme planning, implementation and reporting of the organisation

In identifying the entry points, it is crucial to be aware of the comparative strength of the organisation. This will ensure that the organisation does not look at HIV related work as an add on, but instead incorporates it into ongoing work. This, in turn, will also minimize the need for additional financial resources.

While advocating for mainstreaming it is important to be clear about what mainstreaming is and what it is not. Mainstreaming means making use of the outreach infrastructure and access that the organisation/ institution has to disseminate HIV messages. Such mainstreaming thus can enable wide dissemination and outreach at low cost. Mainstreaming, inter alia, means that the organisation/institution also undertakes to integrate HIV and AIDS in its ongoing schemes/activities/ programmes on a free/low incremental cost basis as a part of its social responsibility.

what mainstreaming is	what it is not
It is a strategy to engage different sectors in HIV and AIDS response	It is not a way of transferring responsibility from NACO/SACS to other organisation
It is based on the comparative strength of the organisation	It does not require any change in the core functions of an organisation and does not use a one-size-fits-all approach
It requires identification of clear entry points	It does not mean every organisation has to do everything. Activities that are not relevant to an organisation must not be pushed on it
It is an interactive process and can be slow in the beginning	Organising a workshop on HIV and AIDS doesnot mean mainstreaming is complete. But it can be beginning of the process
It requires nomination of a senior staff as focal point	It does not mean everyone in an organisation has to become an HIV and AIDS specialist
It is initiated and sustained by commitment at various levels particularly among decision makers	It is not a cost-intensive and complicated, process. If organisations decide to mainstream, there are various ways of minimising costs
It must be catalysed through sustained advocacy	It must be catalysed through sustained advocacy
Implementation is a spirit of partnership and sharing	It is not paying for services or facilities such as rental or space for advertisement, etc. at market rates but leveraging their infrastructure for HIV/AIDS

3.2. Mainstreaming and Partnership Strategic Approach



HIV/AIDS is not a mere health issue as its occurrence is influenced by a number of socio-economic elements. Health interventions alone, therefore, cannot lead to prevention. HIV prevention requires a concerted collaborative effort from all departments, institutions or Organisations in public life through their work and programmes.

The operational definition of mainstreaming used by NACO is the "Integrated, inclusive and multi-sectoral approach which transfers the ownership of HIV/AIDS issues - including its direct and indirect causes, impact and response to various stakeholders, including the government, the corporate sector and civil society Organisations". The focus of all Organisations in mainstreaming is to adapt their core business to respond to the challenges of HIV/AIDS.

Mainstreaming approaches to HIV have increasingly gained ground with the realization that the non-health sector can play an important and meaningful role in reducing vulnerability to HIV and mitigating its impact on those infected and affected. Though HIV is preventable, currently there is no cure for it. It can be best described as "a manageable condition". In this scenario, mainstreaming and partnership for risk reduction, Social Protection, access to service and stigma reduction, become key policy tools to help communities become resilient and cope better.

3.3. Objectives

- a) Strengthen multisectoral response through synergies and coordinated efforts across different players like department, public and private sectors, civil society, institutions and autonomous bodies, health and non health sectors to optimize resource utilization and maximise impact.
- b) Build capacities of key institutions at various levels to initiate activities on risk reduction, integration of HIV related services and Social Protection to mitigate the impact of HIV through improved quality of lives of People Living with HIV (PLHIV) and High Risk Populations (HRGs).
- c) Creation of an enabling environment through policies, programmes and communication strategies.
- d) Amendment of policies programmes and Social Protection schemes appropriately to support needs of PLHIV and HRG.

Mainstreaming intends

- Strengthen government's response to HIV through integrating HIV in the ongoing activities of all its Departments.
- Involvement of public and private sectors in HIV programmes through workplace policy and workplace intervention on HIV.
- Involvement of Civil Society Organisations for greater coverage of HIV programme ensuring community ownership.

- Capacity building of People living with HIV and facilitating access to social and legal protection through amendment of government schemes/ policies in the best interest of PLHIV

The key focus areas under NACP IV are:

- Creating an enabling environment through policies, programme and communication.
- Facilitating expansion of key STI/HIV/AIDS services through integration with health systems of various stakeholders.
- Designing & modifying policies, programmes and schemes to support Social Protection needs of PLHIV, MARPs and CABA.

3.4. Key constituencies

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

a. Government:

This includes key Ministries and Departments (Central, State, District, Block levels, including convergence with other departments within Health Ministry) Public Sector Undertakings, Panchayati Raj Institutions, Urban Local Bodies, Armed forces, Police and Paramilitary forces, Railway Protection Force, Judiciary, Parliament/legislature, Statutory Authorities/Regulatory Bodies, Central and State owned universities, laboratories and special bodies (such as ICMR, CSIR, DRDO).

b. Civil Society:

This includes Not-for-profit Organisations, Community Based Organisations, Faith Based Organisations, and positive networks of people living with HIV, Local self-governance units at the grassroots level in rural and urban setting are also included in this category.

c. Public and Private Sector:

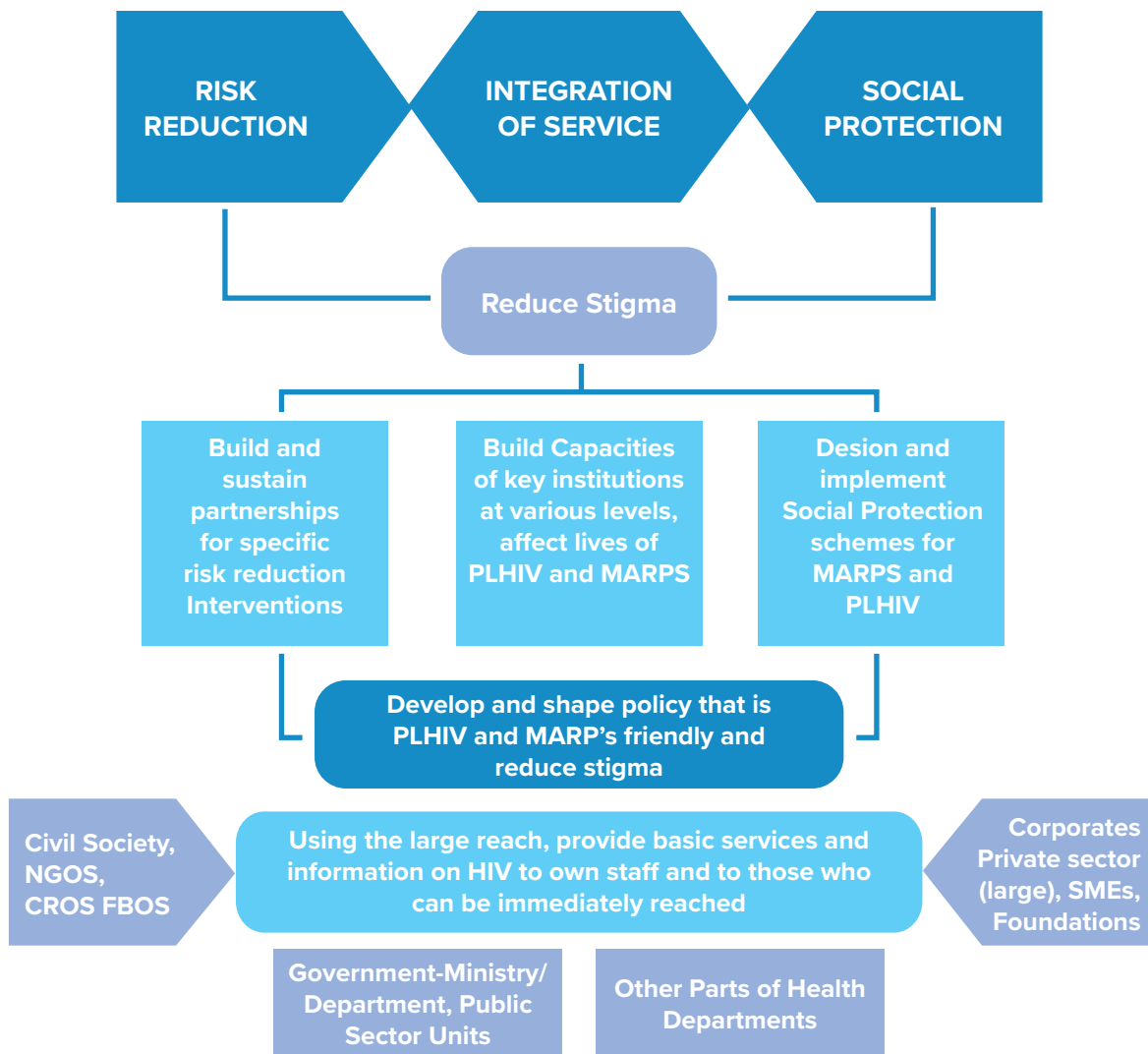
This includes industries of Public and Private Sectors, Employer Organisation, Small and Medium Enterprises (SMEs), and CSR Foundations

d. Development Partners:

Development partners at national and state level such as World bank, GFATM, DFID, UNAIDS, UNDP, UNICEF, ILO, UNFPA, UNWOMEN, BMGF etc.

3.5. Vision for mainstreaming

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





3.6. Strategies for Mainstreaming and Partnership during NACP IV

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

A. Mainstreaming for prevention

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

Most of the partners have substantial reach - Government Ministries/Departments, Public and private sector in particular- through their vast number of employees, supply chain employees and the health & extension services they provide. These partners may be encouraged to mainstream HIV messaging in the existing mechanisms of information delivery.

Build capacities of key institutions at various levels

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

B. Mainstreaming for scaling up of HIV/AIDS services

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

Workplace programmes can raise awareness, support prevention, expand access to information and health services and prevent discrimination of workers infected or sick. Workplace has a vital role to play in the wider struggle to control the epidemic, as it affects workers and their families, enterprises and the communities which depend on them. HIV has negative effects amongst the workplace in terms of loss of income & benefit, loss of skills and experience, falling productivity and reduced profit. Thus HIV/AIDS needs to become a part of workplace health promotion policies. Discrimination and stigmatization against people living with HIV threaten fundamental principles and rights at work and undermine efforts for prevention and care.

C. Mainstreaming for Social Protection

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

HIV and AIDS can push people and households into poverty, in part by reducing household labour capacity and by increasing medical expenses. In some cases, HIV-related stigma and discrimination marginalises PLHIV and households affected by the HIV epidemic and exclude them from essential services. The humanitarian case for taking action to prevent the spread of HIV and AIDS is in itself a compelling one. The impact is felt on income, employment, consumption expenditure (especially nutrition, education and health care) and savings. To conquer the epidemic and reduce its staggering burdens on households and families considerably greater efforts and resources will be needed. Partnership for mitigating the impact is important as provision of social and legal protection to communities infected and affected by HIV.

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

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

3.7. Expected outcomes

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



4. Stigma and Discrimination

India is committed to 'Ending the AIDS' epidemic as a public health threat by 2030 in line with Sustainable Development Goals (SDG). This ambitious target cannot be achieved without meeting the needs of people living with and affected by HIV, and the determinants of health and vulnerability, being addressed. The people living with HIV often experience stigma and discrimination. HIV-related discrimination is grounded in stigma that attaches to people living with HIV and their families; and often in already stigmatised populations, such as female sex workers, men who have sex with men, transgender people, people who use drugs etc. The concerns of these fragile communities must therefore be at the forefront of sustainable development efforts. (Handbook on Prevention and Management of Stigma and Discrimination Associated with HIV & AIDS, NACO 2022).

The human rights framework in India is governed by the Constitution of India and the Protection of Human Rights Act, 1993. The Constitution of India through its Articles 14, 15 and 16 guarantees the right to equality and provides against discrimination and equality of opportunity in matters of employment. The Article 21 provides for protection of life and personal liberty. HIV-related stigma and discrimination are violations of human rights and undermine public health efforts to tackle HIV and AIDS. The journey is encountered by many challenges and HIV-related stigma is considered one of the foremost barriers to effective responses to the HIV and AIDS epidemic.

In a research by International Centre for Research on Women (ICRW), a non-profit organisation outlines the possible consequences of HIV-related stigma as: loss of income and livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of caregiving in the home, loss of hope and feelings of worthlessness, loss of reputation. The human rights approach would prove to be a long-term investment for HIV epidemic treatment and prevention. There is a need to bring an understanding between the rights of the individual, who is at risk of exposure and condemnation because of stigma, and the rights of the rest of the society for the effective development of large scale effective public health programme.

Fear of these consequences keep people away from seeking HIV information, adopting preventive behaviour, getting tested, disclosing their sero-status and accessing treatment. As a result, stigma and discrimination compromise AIDS responses and drive the spread of HIV.

4.1. HIV related Stigma and what is it?

Stigma refers to negative beliefs, feelings and attitudes towards people living with, or seen to be linked to HIV. Stigma also promote social exclusion. Stigma is a socially debilitating label that makes the stigmatized person or group feel secluded from mainstream society. (Goffman, 2009) Stigma often lies at the root of discriminatory actions denying the right to healthcare, work, education, and freedom of movement, among others. It is expressed in stigmatising language and behaviour, such as shunning and avoiding everyday contact, verbal harassment as well as physical violence.

Stigma may also be internalised by stigmatised individuals in the form of feelings of shame, self-blame and worthlessness. On a personal level, stigma may mean loneliness, abandonment, ostracism, violence, starvation and death. Internalized stigma or self-stigma occurs when a person living with HIV agrees with the negative attitudes associated with HIV and accepts them as applicable to themselves.

Other stigma experiences are perceived stigma, which refers to perceptions about how stigmatized groups are treated in a given context, and 'Anticipated stigma, which refers to expectations of bias being perpetrated by others if their health condition becomes known (Evidence for eliminating HIV-related stigma and discrimination. (UNAIDS, 2020).

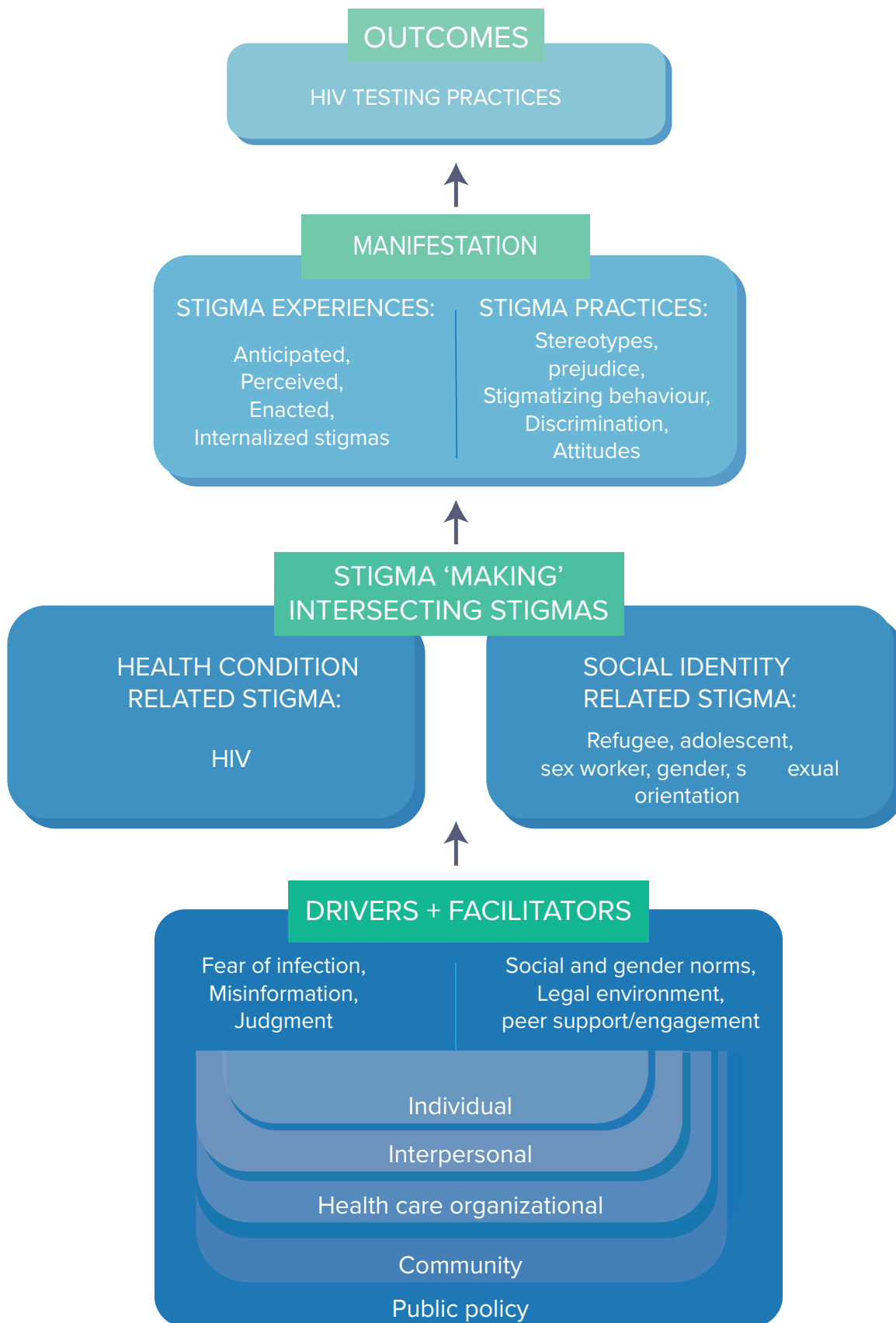
'Courtesy stigma, also referred to as 'stigma by association, involves public disapproval evoked as a consequence of associating with a stigmatised individual or group for e.g., stigma experienced by family members, healthcare and other service providers (Rachel Phillips, et.al.,)

Discrimination refers to the unfair and unjust treatment of someone based on their real or perceived HIV status. It is blaming and showing negative emotions onto a certain group/ population, attributing them or their morals to be the cause of their illness (Gilmore & Somerville, 1994).

It adversely affects family and friends, and those who care for people with HIV. Discrimination is often fuelled by myths of casual transmission of HIV and pre-existing biases against certain groups, certain sexual behaviours, drug use, and fear of illness and death.

'Covert discrimination' is defined as discriminatory behavior that can be justified by the context as neutral or even moral behavior (Lennartz C, Proost K, Brebels L. 2019).

The National AIDS Control Programme over the years have made efforts in understanding and responding to HIV related stigma and discrimination. Various studies have indicated that the structural causes of stigma and discrimination are as follows:



Source: Journal of the International AIDS Society

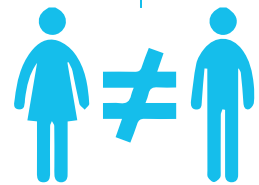
4.2. Economic Inequality

HIV-related stigma negatively impacts the health and well-being of people living with HIV, with deleterious effects on their care, treatment and quality of life. Lack of employment, shelter, food security and the burden of HIV treatment and at times forced migration for living increases vulnerability and drastically reduces self-esteem resulting in increased self-stigma. Highlighting economic status of PLHIV rather than their positivity status would help reduce stigma.



4.3. Gender Inequality

Stigma is at its peak among the MSM and TG population. Women account for a growing proportion of people living with HIV and experience higher levels of poverty and encounter greater barriers to accessing services because of multiple work and child-care burdens, restricted mobility, and economic dependence upon men. The traditional patriarchal societies put women at higher risk of HIV infection. The social hierarchy and the differential power relations that exist, blame women for bringing the infection in the family, especially seen when the woman has been tested for HIV before the husband, as happens in several antenatal clinics. Women have greatest risk because of husband's behaviour ranging from 1 percent in general population of antenatal cases to 14 percent in monogamous women attending STD clinics. Gender norms combined with taboos about sexuality have a huge impact on the ability of adolescent girls and young women to protect their health and prevent HIV, seek health services and make their own informed decisions about their sexual and reproductive health and lives.



4.4. Lack of knowledge

The greatest fear is that of transmission which arises out of myths and misconceptions and it is worsened in societies where health literacy is poor. Only one in three young people globally can demonstrate accurate knowledge about HIV prevention and transmission. Knowledge about HIV prevention among young people has remained stagnant over the past 20 years. The National Family Health Survey (NFHS -5) indicates that 21.6% women and 30.7% men have comprehensive knowledge of HIV and AIDS.



4.5. Social and cultural norms

The socio-cultural norms prevailing in the society considers sex as a taboo. As the predominant route of HIV transmission in India is through the sexual route, society has a tendency to appraise the person negatively with HIV. The social stratification in the form of gender, caste and class further accentuate stigma against the infected communities. Certain religious beliefs that condemn homosexuality and substance abuse contribute to or strengthen sources of HIV stigma.





5. Planning Social Protection Intervention

No	Processes	Sub processes and notes
1	Who are these infected and affected people?	List down all the infected and affected people
2	How to plan Social Protection intervention There are some key processes involved in developing a Social Protection intervention plan	<p>Social Protection vulnerability mapping - based on social, economical, cultural and health conditions</p> <ul style="list-style-type: none"> ◆ This is basically to understand the vulnerability factors influencing the health and Behavioural conditions of the HRGs ◆ PRI methods like force field analysis and seasonality mapping shall be used to identify the vulnerability factors ◆ Focus group discussions shall be conducted to gather the information from HRGs - Prepare a discussion guideline for the same ◆ Some quantitative methods like - collecting statistics like - how many have “Ayushman cards”, how many have “Ration cards” etc. shall be explored
		<p>Needs assessment based on their vulnerability conditions (need to do it separately for PLHIV and other HRGs)</p> <ul style="list-style-type: none"> ◆ Prepare a format for the needs assessment ◆ List out all the services available in the state on the one side and check the knowledge and factors
		<p>Depending on the nature of programme – Ensuring Multiple levels of planning – TI, PRI, District & State</p> <ul style="list-style-type: none"> ◆ Planning at TI or PLHIV network level – This will help to identify the needs and potential of available schemes and finalise the appropriateness of schemes for the community member ◆ later to provide facilitation to access it ◆ DAPCU or SACS shall prepare a state and district level availability of potential schemes and their accessing procedures, timelines and give it to intervention units ◆ This collaborative initiative will ensure the quality of plans at intervention levels
		Information gathering from HRG and other key stakeholders to plan the services availability and accessibility

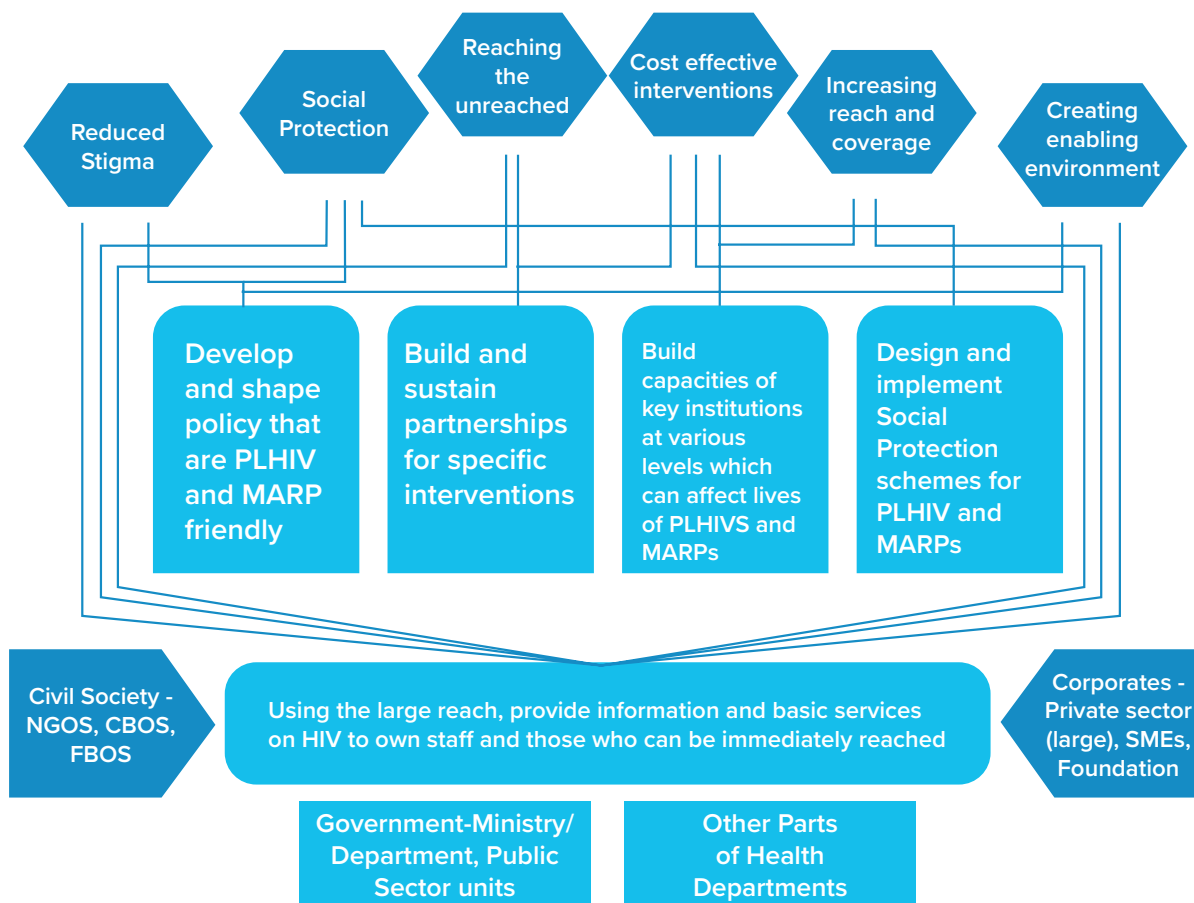


6. Establishing Partnership & Resource Listing

HIV and AIDS being a complex problem, a health response is insufficient. It requires a multi-faceted and multi-sectoral response to address causes and consequences. Therefore, central to this logic is Mainstreaming and Partnerships. For the purposes of the AIDS response in India, Mainstreaming and Partnership is defined as:

An integrated, inclusive and multi-sectoral approach that embeds ownership and empowers various stakeholders (Government, Civil Society and Corporate Sector) to respond to the challenge of HIV and AIDS, using their core competence and assets (human, technical, financial) in a co-ordinated manner leading to a comprehensive and effective national response.

To supplement the above definition, Mainstreaming and Partnership in AIDS addresses direct and indirect aspects of HIV and AIDS within the context of the normal functions of an Organisation or community. It is a process whereby a sector analyses how HIV and AIDS can impact it now and in the future; how sectoral policies, decisions and actions might prevent the spread of infection and mitigate the impact on long term basis. To respond effectively, it requires exceptional responses that demonstrate timeliness, scale, inclusiveness, partnerships, innovation and responsiveness. Actions need to be incorporated into sectors' normal operations while simultaneously continue seeking innovations and extending new partnerships. Mainstreaming HIV and AIDS is a collective and iterative process of learning, engagement, action, experimentation and reflection. Mainstreaming offers a much needed opportunity to look at HIV from a broader perspective than just the biomedical angle; it offers the opportunity to identify and act upon possible synergies with aspects of broader development agenda.



6.1. Resource Mapping

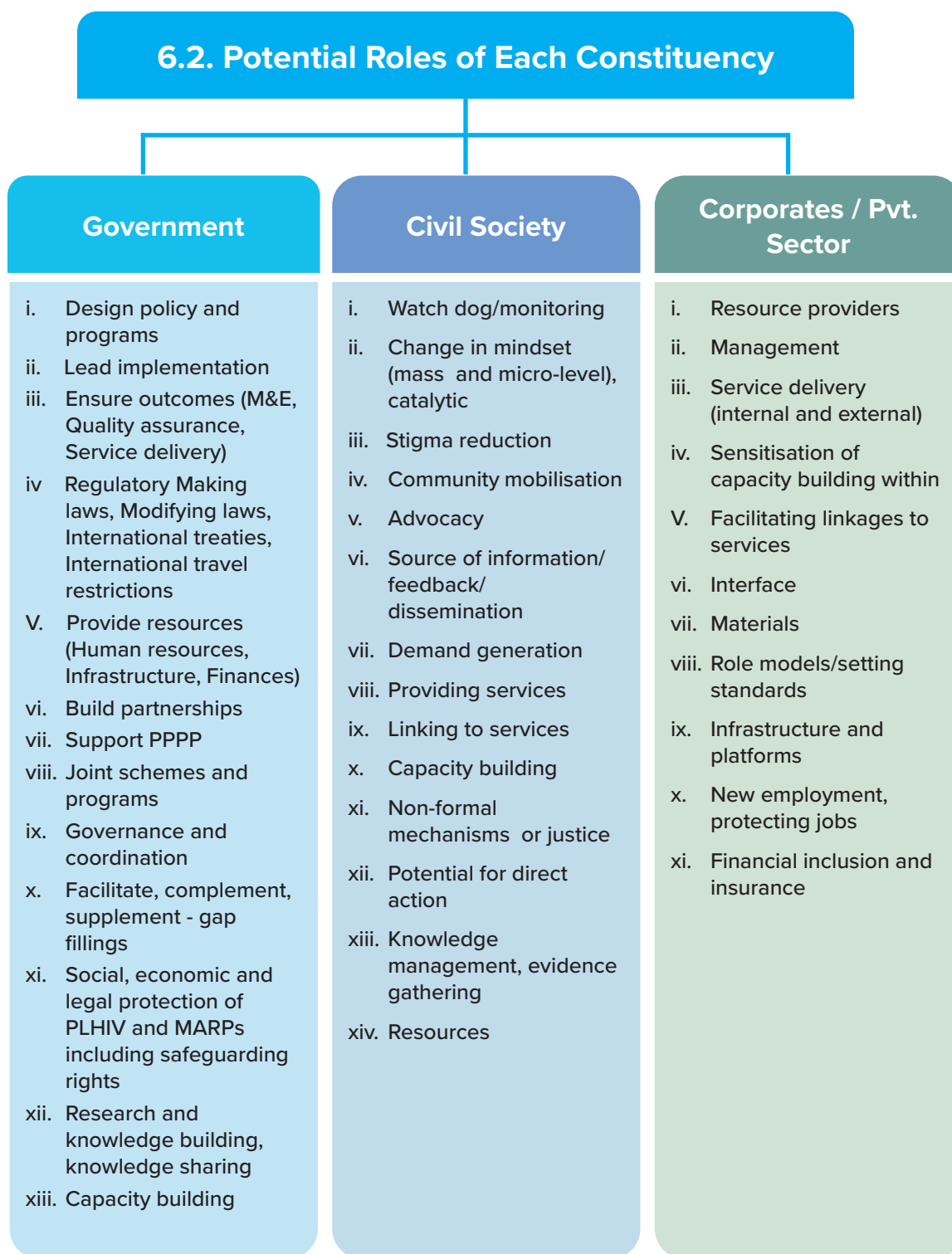
It is a process of identifying and enlisting potential support schemes both in government and private sectors which will be useful in improving the quality of life of community (and their dependents) catered through the HIV/AIDS programmes.

These methods could be used. online searches, individual consultations, officials and key resource persons, concerned office visits, secondary data search, consulting beneficiaries who already accessed services. However, it has to be updated periodically.

Potential private individuals and institutions who are willing to provide charity services also has to be identified and listed.



6.2. Potential Roles of Each Constituency





7. Stakeholder Management and Advocacy

7.1 Stakeholder analysis and management

Need to ensure stake of various potential departments, private sector players and individuals in supporting key population/communities. Based on the resource mapping, potential stake of the partners shall be defined and their usefulness in supporting the community shall be analysed. How it is going to reduce the vulnerability and support in improvement of quality of living. Based on the analysis, intervention plans shall be developed at project level or district level or state level.



Source: https://www.researchgate.net/figure/Stakeholder-management-model_fig12_308612167

7.2. Advocacy and Coordination

Set up Social Protection coordination committees at project, district and state levels. At State level, identify nodal officers in each line department and include them in the coordination committee. The committee shall meet once in 6 months.

In the same way, at district level also such committees are formed and make it functional.

Project level it should be with officials as well as with retired officials who have good knowledge about the same. In addition to the officials committee meetings, individual meetings also shall be planned on a periodic basis to ensure their support in providing the services to the needy community.



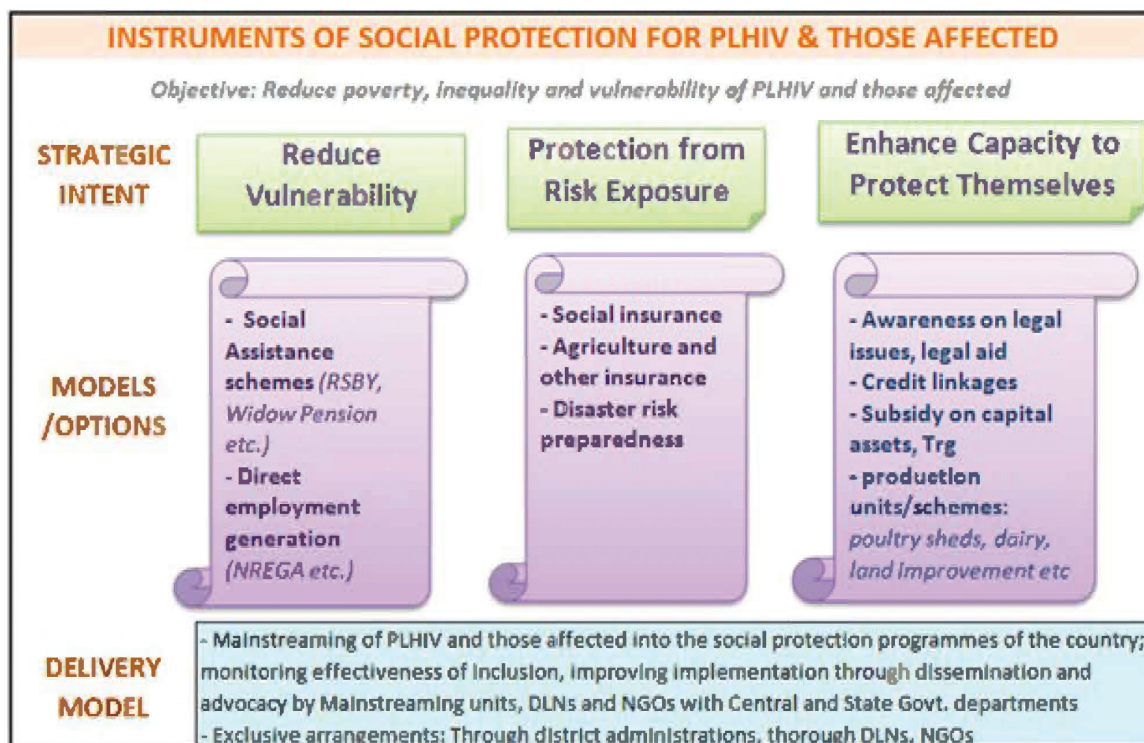
8. Implementing Social Protection Intervention for Communities

What is Social Protection:

Social Protection is designed to reduce poverty, inequality, vulnerability and multi-dimensional deprivation of specific population groups. Social Protection is a set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner); the provision of health care; and, the provision of benefits for families with children (ILO Definition: ILO: World Labour Report: Income security and Social Protection in a changing world (Geneva, 2000) p. 29; ILO: Principles of Social Security (Geneva, 1998) p. 8).

Need for Social Protection:

Social Protection aimed at improving quality of life of PLHIV has been seen a priority for the National AIDS Control Programme in India. National AIDS Control Organisation (NACO) through its mainstreaming department has been making all efforts in this direction. The response of Indian state for providing Social Protection to PLHIV and those affected can be understood through a World Bank framework of Social Protection which categorizes Social Protection as protective, preventive and promotive.



Three-pronged strategy is suggested to deliver the Social Protection programme for PLHIV and HRG in India:

- ▶ **Modifications in existing schemes** (many schemes where it is necessary) To make PLHIV & HRG better eligible to seek the benefits. Modification of schemes where possible should be facilitated. Some of the already existing Social Protection schemes can be modified to add special services or service provisions that are needed or relevant to PLHIV, besides the existing services.
- ▶ **Exclusiveness:** There are certain needs that are specific to PLHIV & HRG, which are linked to their survival. Specific needs such as treatment, nutritional support etc. Besides, sensitivity surrounding the infection makes it important to maintain confidentiality, requiring some of the essential schemes be exclusive and accessed through channels that will ensure stigma free environment and facilitate access.
- ▶ **Inclusiveness:** Certain Social Protection schemes that already exist may not require any modification in the scheme provision but only to include the PLHIV & HRG in the list of beneficiaries. Reaching these communities with benefits of Social Protection schemes requires their access to mainstream programmes and schemes.

While taking this three-pronged approach, the mainstreaming department of NACO along with mainstream team within SACS should identify relevant schemes and work towards steps and strategies for modification of schemes as well as including the PLHIV & HRG. Based on the needs assessment study, if there are needs, not being addressed by the existing schemes, initiate new exclusive schemes for the PLHIV & HRG with the support of the line departments.

In order to improve design and implementation of Social Protection systems, key pre-requisites are given below:

- **Pro-Poor Governance approaches** of the state governments that recognizes the issues of the PLHIV & HRG and responds quickly. Good governance results in growth as a desirable result but not a sufficient condition for poverty reduction.
- **Recognition of PLHIV & HRG issues:** Availability of adequate evidence to highlight the needs of PLHIV & HRG and government recognizing the issues of these communities as needing attention and action.
- **Designing appropriate schemes,** that takes care of the context and need of the PLHIV & HRG, respecting their rights to confidentiality and non-stigmatizing environment.
- **Effective mechanisms for Delivery:** Efficient mechanisms that ensure effective delivery of the services to the PLHIV.

9. Steps in Planning Social Protection Intervention



No	Processes	Sub processes and notes
1	SACS take decision to follow NACO guideline for setting up Social Protection intervention	<ul style="list-style-type: none"> ◆ SACS officially document the same and report it to Executive committee
2	Formation of core group at state level to plan and monitor Social Protection interventions	<ul style="list-style-type: none"> ◆ Under the chairmanship of SACS PD ◆ Include members from ◆ SACS GIPA Coordinator, DD TI, IEC etc. ◆ DAPCU ◆ TI ◆ PLHIV network
3	Set up a professional team to do a resource listing	<ul style="list-style-type: none"> ◆ Through secondary data and direct information gathering prepare a resource list of all the welfare schemes available both at private and government agencies. ◆ Engage TI projects and PLHIV networks also in the process to collect the information ◆ Prepare the list schemes, procedures to access the schemes and how to facilitate
4	Interdepartmental coordination meeting	<ul style="list-style-type: none"> ◆ Organize a round table meeting of all the potential agencies - both in government and private ◆ Make a presentation on what is expected and how to work together ◆ Suggest them to depute a nodal person from each department ◆ Also suggest them to depute a nodal person at district level also
5	Setting up communication channel	<ul style="list-style-type: none"> ◆ Set up social media or email groups to facilitate the processes ◆ Make the group active by sharing information on a regular basis
6	Orientation workshop for the SACS supported service units. on Social Protection interventions and plan of action	<ul style="list-style-type: none"> ◆ Organize either state level or district level workshop for the service providing units of SACS and brief them about the Social Protection programme and the plan.

No	Processes	Sub processes and notes
		<ul style="list-style-type: none"> ◆ Invite few district level officers of other departments and introduce them to the service centers ◆ Orient the partner Organisations about the need and methodology of needs assessment and listing of resources at their project level
7	Linking SACS supported units/ partners/ projects/service centers and potential resource departments/ agencies	<ul style="list-style-type: none"> ◆ Give the departments and agencies, the information regarding the SACS projects and how they function ◆ If needed, make a social media group
8	Needs assessment with communities	<ul style="list-style-type: none"> ◆ SACS partners do a needs assessment among the community members and prepare a list of supports needed ◆ Prepare a detailed plan to link the needs and available schemes
9	Integrating Social Protection intervention into the proposal development processes for TI and other SACS supported projects	<ul style="list-style-type: none"> ◆ Incorporate the provisions to support or facilitate community members in accessing the Social Protection schemes in the concerned areas ◆ Fix monitoring indicators also ◆ Give a provision in the reporting status about the social and economic status of community and status of Social Protection scheme accessibility
10	Training of project based team	<ul style="list-style-type: none"> ◆ Organize training for all the team members in the project to plan and implement Social Protection interventions ◆ Set up monitoring indicators for each of the team members
11	Prepare a detailed plan for accessing Social Protection schemes	<ul style="list-style-type: none"> ◆ Individual community level plan has to be developed under each service delivery units including TI and PLHIV projects
12	Orient the district authorities and DAPCU about the new initiative through advocacy visits	<ul style="list-style-type: none"> ◆ The manager or key person in the project visit the district officials and brief them about the initiative
13	Monitoring systems	<ul style="list-style-type: none"> ◆ SACS, TSU and DISHA/DAPCU officials incorporate the results of these interventions in the monitoring platform ◆ In the periodic experience sharing meeting social interventions will be presented as separate success indicator ◆ This shall be included as a indicators in the monthly reporting formats

10. Action Plan Development



10.1. Key components in the action plan

- Define the categories of interventions based on recourse mapping exercise and needs analysis
- Plan interventions for each department service accessibility - e.g., for social justice department, civil supplies department, women & child development department etc.
- Make result oriented time frame - it should be for each processes which leads to outputs - for e.g., application submission for ration cards, verification completed, ration card issued etc. Plan it accordingly for each service
- Prepare a process based Gantt chart for the plan - to monitor time frame
- Allocate responsibility to officials at multiple levels and integrate it into the existing reporting systems to monitor it properly
- Develop a monitoring format for the project level interventions and ensure that it is reported periodically
- State and district level plans need to be prepared for a year and need to present it in the concerned committees



11. Identifying Change Indicators and Integrating into Existing MIS

11.1. Defining change indicators

Indicators of change are used to track the extent to which an intervention is producing the changes anticipated in the results chain. At least one relevant indicator needs to be defined for each level of the chain, i.e., for outputs, intermediate outcomes, outcomes and impacts.

Indicators can be either qualitative or quantitative, but need to correspond to the change they are trying to measure, and also fulfil SMART principles (i.e., be specific and precisely defined, measurable, and defined within a specific time frame). It is also important to consider whether indicators are realistically measurable given time and resource constraints.

Performance measurement is a key tool to assess how well a programme or policy achieves its objectives, and identifying the appropriate indicators is critical for this to be achieved effectively. Performance measurement has three main functions: i) to make the most of limited resources; ii) to increase accountability and transparency and iii) to improve decision-making by providing relevant information to inform policy decisions for ensuring effectiveness of Social Protection interventions.

11.2. Current indicators:

At SACS level

PLHIV active and alive on ART

No. of PLHIV accessing various schemes (Scheme wise)

No. of HRG. Category wise

No. of HRG (category wise) accessing various schemes (Scheme wise)

For various departments

No. of advocacy meetings conducted.

No. of trainings conducted.

No. of JWGs formulated.

No. of JWG meetings conducted.

No. of decisions taken

No. of decisions implemented.

At NACO level

No. of SCAs formulated.

No. of SCA meetings conducted.

No. of Legislative forums formulated.

No. of Legislative forum meetings conducted.

12. Case Study



12.1. Introduction:

Case study is a qualitative research method. This may include theory, phenomenology, discourse and other events. One can use different approaches to design the study, generate data, analyze the data and disseminate the findings. The approach is to create a learning environment through the case studies within the programme. The learning will also include discussion of the qualitative research reports from various field work activities. Thus, the process will majorly include a collection and presentation of detailed information about a particular participant or a group. The case study exercise of this field work will showcase the process of our target group accessing social and legal protection scheme by our target group. This, however, requires a prior approval of individuals, groups and Organisations.

A Case study is a story about interesting event of individuals, Organisations, processes, programmes, and institutions, etc. In this project, the case studies will highlight the process of accessing social and legal protection for PLHIV and HRGs. It would capture the events that has happened and will underline the success, challenges and difficulty of a project.

12.2. Types of case study:

There are various methods of case study that can be used in this project (Facilitating access to social and legal protection for the most marginalized communities. The following types can be used for case studies with PLHIV and HRGS.

- **Exploratory Case Studies:** This will include collecting basic information on the social and legal protection programmes accessed by the PLHIV, MSM and FSW. The process of getting the benefit of the scheme and the hindrances faced in acquiring the schemes will be documented.
- **Illustrative Case Studies:** This means that case study will show the situation that one is unfamiliar about. The case study will bring to fore the gravity of the problems faced by the PLHIV and MARPs in accessing social and legal protection schemes. Through these case studies, the service providers will understand about the PLHIV and HRGs and will be expected to show readiness to facilitate the PLHIV and HRGs in accessing social and legal protection schemes available in the state and country.
- **Critical Event Case Studies:** In this study the case cannot be generalized but it highlights the importance of the event. This would relate to the cause and effect events of PLHIV and HRGS. PLHIV, MSM and FSW are the special category of people therefore they will have unique experience in accessing social and legal protection schemes. In this critical event case study, it is important to record their every experience.

12.3. Preparations for case study:

PLHIV and HRGs belong to a group that is less supported by the society due to the conditions and behavior of action in relation to HIV. Therefore, one needs to understand, keep in mind that PLHIV and HRGs have their own community and live accordingly. Following are some of the points to be kept in mind before conducting the case study.

- ▶ There are no single answers to question.
- ▶ Make oneself familiar with PLHIV and actions of HRGs.

Requirements to be followed to arrive at the purpose:

- ▶ Be prepared for interaction with PLHIV, MSM and FSW.
- ▶ Time limit has to be taken into account for both client and interviewer.
- ▶ Structured format of question to be followed in case study.

12.4. Purpose of current proposed case study:

The purpose of doing this case study is to show the process of accessing the social and legal protection by PLHIV and HRGs. The purpose of these case studies is to highlight the successes, the difficulties faced and the challenges of PLHIV and HRGs in receiving the benefit or the reasons for the non-receipt of the social and legal protection schemes in the state. These case studies will lead to help in planning and implementing social and legal protection schemes for HRGs and PLHIV.

12.5. Do's and don'ts of case study:

Do's:

Take informed consent of the respondent before conducting case study

- **Be specific and to the point.**
- **Tell about the organisation one belongs to and what work it does.**
- **Make clear the objectives for conducting of case study.**
- **Tell that the information will be disseminated.**
- **Explain what would be the possible benefit for the community.**

Try to make yourself comfortable with the community, by being acquainted with their contexts and perceptions.

Don'ts

Never be a general about the objectives of the visit and the case study collection.

Do not promise any kind of support.

Do not show discomfort when with the community.

12.6. How to write a case study:

Case study is a story. This should be narrated according to the actual information. First, the case study would explain the background, the process followed to get the information from the community (including PLHIV, MSM and FSW). While writing the report one needs to specify the group that the individual belongs to and certain information about the individual. This will be followed by a narration of the statements of the respondents, and the analysis of the process and information collected. Present the data to the stakeholders for decision making. Add appendix to the case study. Write the case study in a manner that attracts the readers and stakeholders for making easier the process accessing the social and legal protection schemes.



12.7. Annexure



12.7.1 Informed Consent Form

I/we _____ belong to and we are involved in understanding the process of the access of the Social Protection schemes that you have tried to access. We would like to know the process of your access, and reasons (if any) of non-access. We would use this information to compile a report, which would feed into the planning for the future schemes of benefit.

On behalf of our Organisation, I/we promise that all your information will be kept confidential. Your name and the place will appear in our publications if you allow our Organisation to publish the same.

On behalf our Organisation, I/we would take an hour for interviewing you. You may discontinue the interview anytime if you do not feel comfortable with me/us.

I/We on behalf of our Organisation are thankful and grateful for your support in enriching our Organisation with your valuable experiences.

Thanking you

I/We, _____ have no objection to provide a narration of my present condition. I/we would explain to the world about the condition, in which I/we live by the assistance of your Organisation. I/we do not hesitate and promise that my/our statements and photos could be published by your Organisation's publication.

Signature of interviewee

Date



12.7.2. Structure for Writing a Case Study for PLHIV and HRGs

Name	
Sex	
Age	
Place	
Present condition of PLHIV and HRGs	
Linkage with Network	
Support from network	
Support of the service providers	
Benefit of the scheme	
Suggestions for accessing the services	

Annexure I

Energisers



Energisers



An energiser is a short activity that's designed to actively engage the participants and refresh their mind when attention levels have dropped. Energisers often require the participants to get off their chairs and move around and interact with others.

Facilitators use games for a variety of different reasons, including helping people to get to know each other, increasing energy or enthusiasm levels, encouraging team building or making people think about a specific issue. Games that help people to get to know each other and to relax are called ice breakers. When people look sleepy or tired, energisers can be used to get people moving and to give them more enthusiasm. Other games can be used to help people think through issues and can help to address problems that people may encounter when they are working together. Games can also help people to think creatively and laterally.

Things to consider when using Energisers

- ✓ **Try to** use energisers frequently during a workshop or meeting, whenever people look sleepy or tired or to create a natural break between activities.
- ✓ **Try to** choose games that are appropriate for the local context, for example, thinking carefully about games that involve touch, particularly of different body parts.
- ✓ **Try to** select games in which everyone can participate and be sensitive to the needs and circumstances of the group. For example, some of these games may exclude people with disabilities, such as difficulty walking or hearing, or people with different levels of comfort with literacy.
- ✓ **Try to** ensure the safety of the group, particularly with games that involve running. For example, try to make sure that there is enough space and that the floor is clear.
- ✗ **Try not to** use only competitive games but also include ones that encourage team building.
- ✗ **Try to** avoid energisers going on for too long. Keep them short and move on to the next planned activity when everyone has had a chance to move about and wake up!

1. What's your Birth month?

Ask the participants form groups as per their birth months. A total of twelve months. Participants would move around and check with others. This could also be an icebreaker as they start asking directly about others birth months..



2. Who's the Tallest/shortest?
Make an ascending or descending single line as per their height.

Ask the participants to stand in a single line as per their height. Tall people to short or the reverse as per the facilitator's or the participants' choice. This would be a fun activity with lots of verbal and nonverbal communication among the participants.



3. Which group can create a longest line?

Ask the participants to create a longest line of things they have on them at the unoccupied side of the training hall. They can use the object they are carrying on them like, pens, spectacles, shoe/footwear and sometimes shoelaces also, if they think out of the box. The facilitator should instruct clearly that they cannot use their jackets or dupattas, basically asking them not to use part of the clothes they are wearing. This would help them discuss among them and have a healthy competition among other groups. At the end of the given time, the facilitator should measure the length of each group line/chain with his/her feet. The winning team would get a big round of applause by entire participants.

4. Who's wearing black/Blue/Red?

To bring back the attention of participants. The facilitator can randomly ask the participants to stand up, whoever is wearing a certain colour on them. This could be any common colour chosen by the facilitators. This would take very little time but very effective to get the attention of the sleepy and tired participants.

5. Married or unmarried?

Ask the participants to move into two separate groups, one side married and another side unmarried towards the unoccupied space of the training hall. Same could be used for vegetarian and non-vegetarian. The facilitator could also use other parameters like, people know more than three or four or above five languages other than their mother tongue. In the similar way, groups could be made as per the number of countries they visited so far. The list can go on. After the participants get a hang of it, facilitator can ask them to suggest more of such parameters. This would also make it more participatory.

In this energiser, the facilitator could use five to ten minutes with few of the variables together. It would help the participants to move on their feet from place to place/ group to group.

6. Make a circle

Ask the participants to stand in small circles as per their group away from their table. They should create chain of hands by holding the alternative person hand standing next to each.

7. Tide's in/tide's out

Draw a line representing the seashore and ask participants to stand behind the line. When

the facilitator shouts “Tide’s out!”, everyone jumps forwards over the line. When the leader shouts “Tide’s in!”, everyone jumps backwards over the line. If the facilitator shouts “Tide’s out!” twice in a row, participants who move have to drop out of the game.

8. Find someone wearing

Ask participants to walk around loosely, shaking their limbs and generally relaxing. After a short while, the facilitator shouts out “Find someone...” and names an article of clothing. The participants have to rush to stand close to the person described. Repeat this exercise several times using different types of clothing.

9. Mirror image

Participants sort themselves into pairs. Each pair decides which one of them will be the ‘mirror’. This person then copies (mirrors) the actions of their partner. After some time, ask the pair to swap roles so that the other person can be the ‘mirror’.



10. Presenting gifts

This can be used at the end of a workshop. Put participants’ names in a box or bag. Pass the box or bag around and ask each person to pick a name. If they get their own name they have to put it back and choose another. Give the group a few minutes to think of an imaginary gift they would present to the person whose name they have drawn. Ask them also to think how they would present it. Go round the group asking each person to present their imaginary gift.

Annexure II

Glossary



Glossary



Advocacy	Advocacy means getting support from another person to help you express your views and wishes, and help you stand up for your rights.
Antiretroviral Therapy (ART)	The treatment for HIV is called antiretroviral therapy (ART). ART involves taking a combination of HIV medicines (called an HIV treatment regimen) every day.
Case Study	<p>A case study is one of the most extensively used strategies of qualitative social research. Over the years, its application has expanded by leaps and bounds, and is now being employed in several disciplines of social science such as Sociology, Management, Anthropology, Psychology and in Development sector also.</p> <p>A case study provides in-depth description of a single unit. The unit could be an individual, group, a site, class, a policy, programme, institution or a community. The characteristics of the unit in question is studied in great detail. It is anchored in real life to provide a holistic description of the context. It can use multiple data collection techniques. Its biggest advantage is the possibility of depth because it seeks to understand a single 'unit' in the totality of its context and environment. Therefore, the past and the present are of equal importance.</p>
Change Indicators	Indicators of change are used to track the extent to which an intervention is producing the changes anticipated in the results chain.
Civil Society	The wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations.
Community Champions	A Community Champion is someone who volunteers within their own local community to promote and enhance people's wellbeing. They are sometimes known as a 'health champion'. It might mean championing healthy living, improving mental wellbeing or attaining better living conditions for their peers.
Consent	Consent is agreement or permission expressed through affirmative, voluntary words or actions that are mutually understandable to all parties involved, to engage in a specific conversation to answer questions in our case.
Corporate	Corporate means relating to large companies, or to a particular large company.
Discrimination	<p>Discrimination is the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age, or sexual orientation.</p> <p>HIV-related discrimination is grounded in stigma that attaches to people living with HIV and their families; and often in already stigmatised populations.</p>

District AIDS Prevention and Control Unit (DAPCU)	As a major structural reform, the management of HIV prevention and control programme was decentralised to district level during the third phase (2007-12) of National AIDS Control Programme-III in the years 2008-09. Using the HIV Sentinel Surveillance data (2004-2006), all the districts in the country were divided into four categories (Category A, B, C and D) based on the disease burden.
District Integrated Strategy for HIV/AIDS (DISHA)	Institutionalising District AIDS Prevention Control Committee (DAPCC) meetings for meaningful engagement of the district administration in HIV. Field visits to the facilities to provide supportive supervision. Co-ordination and integration with health department and mainstreaming with other line departments.
Feasibility Assessment	A feasibility assessment is a study to determine if the requirements of a project or a program can be met within the cost, schedule, and performance constraints of the project or program
Greater Involvement of People Living with HIV/AIDS (GIPA)	GIPA is not a project or programme. It is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives.
High Risk Groups (HRG)	NACO has targeted its preventive efforts towards sub-groups of population identified to be at high risk of acquiring HIV infection. These High Risk Groups (HRGs) include FSW, MSM, Hijra(H)/ Transgenders (TG), IDU and Bridge Populations such as Migrants and Long Distance Truckers.
Ice breaking exercise	An icebreaker is a brief facilitation exercise intended to help members of a group begin the process of working together or forming themselves into a team. Icebreakers are commonly presented as a game to “warm up” the group by helping the members to get to know each other.
Integrated Counselling & Testing Centre (ICTC)	(ICTC) is a place which provides a window for rendering information about HIV prevention, counsels them to undergo testing, and provides testing facilities and also links positive people with treatment, care and support system.
Informed Consent	Informed consent means that the purpose of the research/ study is explained to them, including what their role would be and how the trial will work. A central part of the informed consent process is the informed consent document signed by the respondent.
Injecting Drug Users (IDU)	IDUs have been defined in NACP III as an individual who has injected drugs at least once in the last three months.
Joint Working Groups (JWG)	These Joint Working Groups (JWG) will provide necessary guidance, support and assistance for drawing up an action plan and ensure timely and effective implementation through mutual support as well as engagement of various stakeholders at central/state and District levels.
Mainstreaming	‘Mainstreaming HIV is a process that enables developmental actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work within their workplace’. It implies that the sector determines how the epidemic is likely to affect the sector’s goals, objectives and programmes and where the sector has a comparative advantage to respond to and limit the spread of HIV and to mitigate the impact of the epidemic.

	The operational definition of mainstreaming used by NACO is the “Integrated, inclusive and multi-sectoral approach which transfers the ownership of HIV/AIDS issues – including its direct and indirect causes, impact and response to various stakeholders, including the government, the corporate sector and civil society organizations”.
Men had sex with men (MSM)	The operational definition of MSM was “men who had sex (manual/oral/anal) with other men in the last six months”.
National Council on AIDS (NCA)	National Council on AIDS (NCA) is a committee established through the Act of Parliament to coordinate and facilitate the national multi-sectoral response to HIV and AIDS. State Council on AIDS (SCA) are a state level bodies of NCA.
Needs Assessment	A needs assessment is a process used by organizations to determine priorities, make organizational improvements, or allocate resources. It involves determining the needs, or gaps, between where the organization envisions itself in the future and the organization’s current state.
People infected with and affected by HIV/AIDS (PLHIV)	PLHIV include adults and children that have tested positive for HIV.
Positive Network	It is a network representing all people living with HIV and AIDS. Their main agenda covers sexual and reproductive health/rights, human rights and the empowerment of people living with HIV.
PPP (Public Private Partnership)	The public–private partnership (PPP or 3P) is a commercial legal relationship defined by the Government of India in 2011 as “an arrangement between a statutory / government owned entity on one side and a private sector entity on the other, for the provision of public assets and/or public services.
RBA (Rights Based approach)	The rights-based approach (RBA) is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress and often result in groups of people being left behind. The National AIDS Control Programme (NACP) was also based on these principles.
Resource Listing	Resource Listing means a list developed on, equipment, materials and supplies including the human resources before starting a programme or project.
Resource Mapping	It is a process of identifying and enlisting potential support schemes both in government and private sectors which will be useful in improving the quality of life of community (and their dependents) catered through the HIV/AIDS programmes These methods used are : online searches, individual consultations, officials and key resource persons, concerned office visits, secondary data search, consulting beneficiaries who already accessed services. However, it has to be updated periodically.

	Mapping is a first step toward enhancing essential understanding, and done properly, it is a major intervention in the process of moving forward with enhancing systemic effectiveness.
Risk	In simple terms, risk is the possibility of something bad happening. Risk involves uncertainty about the effects/implications of an activity with respect to something that humans value (such as health, well-being, wealth, property or the environment), often focusing on negative, undesirable consequences.
Sex worker	Sex work is a term used to describe a wide range of activities relating to the exchange of money (or its equivalent) for the provision of sexual services. As per the National Network of Sex Workers, sex workers include female brothel-based sex workers who migrate from various places to work in brothels for a contract and then return home, transpeople who provide sexual services to men, and male sex workers who provide services to other men.
Single window model	Single window refers to a single access point to avail the information on various Social Protection schemes and submit the application for Social Protection. The DAPCU directly advocates with the district administration through the District Commissioner / District Magistrate / District Collector with various departments (including legal services) to make necessary changes in the various schemes to address the needs of the PLHIV, CABA and MARPs.
Social Protection	<p>As per ILO definition: Social Protection is a set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner); the provision of health care; and, the provision of benefits for families with children.</p> <p>Social protection schemes reduce gender and income inequalities and social exclusion, all of which increase the risk of contracting HIV. They also make it easier for people to access HIV and other health services, and can cushion the social and economic impact of HIV on households and individuals.</p>
Stakeholder Management	Stakeholder management is the process by which one organize, monitor and improve the relationships with relevant stakeholders. It involves systematically identifying stakeholders; analyzing their needs and expectations; and planning and implementing various tasks to engage with them.
Sexually Transmitted Infections (STI) Clinics	Control of STI/RTI is an important component of the NACP; during NACP IV, the programme aimed to provide universal, comprehensive and standardized quality STI/RTI services at all health care facilities to all population groups with special emphasis on HRG population and vulnerable groups, including women and adolescents through convergence with NHM and by involvement of private sector.
	These clinics have been branded as “Suraksha Clinics” and provide sexual & reproductive health services. Standardized training to the medical and paramedical personnel based on syndromic case management approach is being provided and counselling services from trained counsellors are made available at these clinics. Colour coded syndromic drug kits and RPR test kits are being centrally procured and supplied to these clinics.

Stigma	<p>Stigma refers to negative beliefs, feelings and attitudes towards people living with, or seen to be linked to HIV. Stigma also promote social exclusion. Stigma is a socially debilitating label that makes the stigmatized person or group feel secluded from mainstream society. (Goffman, 2009)</p> <p>Stigma often lies at the root of discriminatory actions denying the right to healthcare, work, education, and freedom of movement, among others. It is expressed in stigmatising language and behaviour, such as shunning and avoiding everyday contact, verbal harassment as well as physical violence.</p>
Targeted Intervention (TI)	<p>The Targeted Intervention (TI) programme is the flagship prevention initiative of the National AIDS Control Organisation (NACO) for HIV and AIDS prevention.</p> <p>These interventions provide an opportunity to provide comprehensive and integrated HIV prevention as well as care and support services to extremely marginalized High Risk Groups, such as Female Sex Workers (FSWs), Men who have Sex with Men (MSMs), Transgenders (TGs), People Who Inject Drugs (IDU)</p>
Urban Legislative Body (ULB)	<p>Urban Local Bodies (ULBs) are small local bodies that administers or governs a city or a town of specified population.</p> <p>The ULBs execute their functions through constitution of different Standing Committees</p>
VIHAN CSC	<p>The 'Vihaan' (means 'DAWN') project developed by Alliance India is based on the guidance provided by NACO for the care and support component of a well synchronized treatment, intervention; where treatment is managed by civil society interventions.</p>
Vulnerability	<p>Vulnerability describes the characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard. There are many aspects of vulnerability, arising from various physical, social, economic, and environmental factors.</p> <p>Vulnerable groups: People are said to be in a state of vulnerability if their living conditions are prone to shifting factors which would place them at risk of contracting HIV. Examples of those groups are young people, women, migrants, female sex workers, MSM, IDU and others.</p>
Vulnerability Assessment	<p>Identifying and understanding the various factors making certain communities vulnerable to HIV infection.</p>
Vulnerability Mapping	<p>Mapping of the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.</p>

Annexure III

**Compendium of Social
Protection Schemes for people
infected with and affected by
HIV/AIDS, extended by Central
Ministries/Dept. :
A brief Overview**

Social Protection is more than cash and social transfers such as food and vouchers. It encompasses economic, health financing, insurance, employment assistance and social care to reduce poverty, inequality, exclusion and barriers to accessing basic services. The purpose, target groups, scope of benefits and coverage provided by the various Social Protection programmes in each country vary widely; however, the majority of Social Protection programmes around the world are designed to reduce poverty and vulnerability of poor people.

Social Protection programmes include programmes focusing on alleviating poverty and inequality; programmes increasing access to essential services such as health and education; housing programmes; programmes targeting poor and vulnerable people, such as orphans and other vulnerable children, adolescent girls and young women, transgender people and elderly people; and programmes that transform the social, political and economic environment in which people live.

National AIDS Control Programme in India has been focusing on improving access of the People Living with HIV (PLHIV) to the existing Social Protection schemes. Efforts have been made to adapt the existing schemes to include PLHIV (HIV-sensitive) as well as to initiate new schemes that directly address the issues of PLHIV (HIV-specific).

The recent times were impacted by disruptions caused by the COVID-19 pandemic, coupled with Government precautionary lock down to contain spread of the virus had hit hard the Indian economy. Poor and vulnerable populations took the brunt of these measures. Following the announcement of the Nation-wide lockdown, Government of India has announced the implementation of series of Social Protection measures like Cash transfers under National Social Assistance Programme, Pradhan Mantri Jan Dhan Yojana and increase of wages in Public works. Similarly, different State Governments have also announced State specific Social Protection measures for the poor and vulnerable populations. However, the implementation of these measures at the grass root level remains a challenge. Vulnerable populations like People Living with HIV (PLHIV) and High Risk Groups (HRG) like Sex workers, Men having Sex with Men (MSM), Transgender (TG), Migrant workers, etc. face barriers in accessing the basic services like Health and welfare measures due to fear of stigma and discrimination and societal norms. The situation was further complicated in the present COVID 19 Pandemic and prevailing various stages of lock-down.

The information on various schemes was collected largely through available information on various central ministries websites up to December 2020. Data related to PLHIV and other HIV inclusive and exclusive schemes were collected from NACO and SACS and from other publications.



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1. Ministry of Rural Development

Name of the Scheme:

1. **National Rural Employment Guarantee Act 2005 (or, NREGA No 42, later renamed as the “Mahatma Gandhi National Rural Employment Guarantee Act”, MGNREGA)**

Brief details of the Scheme:

It was initiated with the objective of “enhancing livelihood security in rural areas by providing at least 100 days of guaranteed wage employment in a financial year, to every household whose adult members volunteer to do unskilled manual work. Another aim of MGNREGA is to create durable assets (such as roads, canals, ponds, wells). Employment is to be provided within 5 km of an applicant’s residence, and minimum wages are to be paid. If work is not provided within 15 days of applying, applicants are entitled to an unemployment allowance.

Eligibility:

1. All rural households who are in need of wage employment and desire to do manual and unskilled work.
2. Period of employment is at least fourteen days continuously with not more than six days in a week.
3. at least one third of wage seekers are women.
4. Persons desirous for work to submit their applications to the Gram Panchayat.
5. Gram Panchayat to register the household. After verification, job card is to be issued to the applicant household.
6. Gram Panchayat or Block Programme Officer to provide unskilled manual work to the applicant within fifteen days of receipt of application preferably within a radius of 5 kilometers of the village, where the applicant resides. In case the employment is provided outside such radius, it must be provided within the Block and the labourers shall be paid 10% of the wage rate as extra wages to meet additional transportation and living expenses

Entitlements:

1. Right to get Job Card.
2. Right to demand work and get it.
3. Right to Unemployment Allowance.
4. Right to plan and prepare the shelf of project.

Whether PLHIV are included?

In certain states (Bihar, Gujarat, Jharkhand, Kerala, Manipur, Mizoram, Orissa, Rajasthan, Uttar Pradesh and West Bengal) preference is given to People Living with HIV in Job Card (MNREGA). Allocation of work based on individual health condition.

Source:

<https://nrega.nic.in/netnrega/home.aspx>

Name of the Scheme:

2. Pradhan Mantri Awas Yojna- Gramin (PMY-G)

Brief details of the Scheme:

The emphasis under PMAY-G is on providing universal access to housing in rural areas by constructing housing for all during the period of 3 years from 2016-17 to 2018-19 in the State.

Eligibility:

1. Houseless poor families and those living in dilapidated and kutcha houses.
2. Landless poor

Entitlements:

Under this scheme, the beneficiaries are identified as per the SECC-2011 data and households having 0,1,2 room kutcha house. An amount of Rs.1.20 lacs in plain areas and Rs.1.30 lacs in hilly/difficult areas will be provided to the beneficiaries to construct IAY houses. In addition to this, an amount of Rs.18,000/- as Top up amount by the State Govt. and Rs.12,000/- will be provided under convergence for construction of sanitary latrine to the beneficiary. Under MGNREGA, out of total 90 unskilled person days in the plain areas & 95 unskilled person days in hilly/difficult areas will be permitted employment to the IAY beneficiaries for construction of their houses.

Whether PLHIV are included?

Special provisions and priority was given to PLHIV and Widows of PLHIV.

Source:

<https://pmayg.nic.in/netiay/IAY%20revised%20guidelines%20july%202013.pdf>

Name of the Scheme:

3. Deen Dayal Upadhyaya Grameen Kaushalya Yojana

Brief details of the Scheme:

It is a Government of India project to engage rural youth, especially BPL and SC/ST segments of the population, in gainful employment through skill training programmes.

Eligibility:

Rural poor youth between 15 and 35 years of age,

Entitlements:

1. Face to face counseling and guidance
2. Find out what they're good at, get chosen for a skill based on their aptitude
3. Learn new skills and new technology in modern fully equipped training centres
4. Earn a government accepted certificate upon successful completion
5. Get placement opportunities and interact with potential employers
6. Find a job that pays a minimum salary of Rs. 6,000/- per month (at least 75% of all those who successfully completed training will be placed)
7. Get support to shift to a new city and job (if needed)

Whether PLHIV are included?

Yes, the upper-age limit for women candidates, and candidates belonging to Particularly Vulnerable Tribal Groups (PVTGs), Persons with Disabilities (PwDs), Transgender and other Special Groups like rehabilitated bonded labour, victims of trafficking, manual scavengers, trans-genders, HIV positive persons, etc. shall be extended by 10 years to 45 years.

Source:

<http://ddugky.gov.in/>

Name of the Scheme:

4. National Rural Livelihood Mission (NRLM)

Brief details of the Scheme:

This scheme is focused on promoting self-employment and organization of rural poor. The basic idea behind this programme is to organize the poor into SHG (Self Help Groups) groups and make them capable for self-employment.

Eligibility:

At least one woman member from each identified rural poor household, with special emphasis particularly on vulnerable communities such as Manual scavengers,

- Victims of human trafficking,
- Particularly Vulnerable Tribal Groups (PVTGs),
- Persons with Disabilities (PwDs) and
- Bonded labour.

Entitlements:

NRLM focuses on stabilizing and promoting existing livelihood portfolio of the poor through its three pillars 'vulnerability reduction' and 'livelihoods enhancement' through deepening/ enhancing and expanding existing livelihoods options and tapping new opportunities in farm and non-farm sectors

Whether PLHIV are included?

While mobilizing the identified poor into the SHGs, priority would be given to the vulnerable sections like the SCs, the STs, the landless, migrant labour, isolated communities and households led by single women, people with disabilities and people living with HIV/AIDS (PLHIVs) and their caregivers.

Source:

https://aajeevika.gov.in/sites/default/files/resources/national_reports/PIP-NRLM.pdf

Name of the Scheme:

5. Swarnjayanti Gram Swarozgar Yojana (SGSY)

Brief details of the Scheme:

SGSY was launched by restructuring the existing schemes namely:

1. Integrated Rural Development Programme (IRDP)
2. Training of Rural Youth for Self Employment (TRYSEM)
3. Development of Women & Children in Rural Areas (DWCRA)
4. Supply of Improved Toolkits to Rural Artisans (SITRA)
5. Ganga Kalyan Yojana (GKY)
6. Million Wells Scheme (MWS)

It is a holistic scheme covering all aspects of self-employment such as organization of the poor into Self Help Groups, training, credit, technology, infrastructure and marketing. The scheme will be funded by the financial institutions, Panchayat Raj Institutions, District Rural Development Agencies (DRDAS), Non-Government Organisation (NGOs), Technical institutions in the district; will be involved in the process of planning, implementation and monitoring of the scheme. NGO's help may be sought in the formation and nurturing of the Self Help Groups (SHGs) as well as in the monitoring of the progress of the Swarozgaris. Where feasible their services may be utilized in the provision of technology support, quality control of the products and as recovery monitors cum facilitators.

Eligibility:

- Vulnerable, weaker and poor sections of society.
- 50% of those assisted will be from SC/ST category,
- Women will constitute 50%, and
- 3% will be reserved for differently abled persons.

Entitlements:

The scheme aims at establishing a large number of micro enterprises in the rural areas. The list of Below Poverty Line (BPL) households identified through BPL census duly approved by Gram Sabha will form the basis for identification of families for assistance under SGSY. The objective of SGSY is to bring assisted family above the poverty line within three years by providing them income generating assets through a mix of bank credit and Government subsidy. The rural poor such as those with land, landless labour, educated unemployed, rural artisans and disabled are covered under the scheme.

Whether PLHIV are included?

Preference will be given to PLHIV.

Source:

<http://megcnrd.gov.in/forms/SGSY.pdf>

Name of the Scheme:

6. Financing purchase of land for agriculture purposes

Brief details of the Scheme:

Government is encouraging consolidation of land. As part of this, term loan is available to the tune of Rs. 50,000/- to Rs. 10 lakhs to individual Small Farmers / Marginal Farmers / Share cropper / Tenant farmers for purchase of land.

Eligibility:

- Small and marginal farmers who would own maximum of non-irrigated land
- Share croppers/tenant farmers

Entitlements:

1. Loan Amount: Cost of land
2. Provision of irrigation facilities & land development (shall not exceed 50% of the cost of the land).
3. Purchase of farm equipment.
4. Registration charges & stamp duty.
5. Loan amount will be 85% of the cost of the land, as assessed by the bank, subject to the maximum of Rs 5 lakhs Security
6. Mortgage of land to be purchased
7. Max. 9-10 years beginning after the expiry of gestation period, with half-yearly installments. Gestation period will be maximum of 1 year for the developed land and 2 years for the land to be developed.

Source:

<https://sbi.co.in/web/agri-rural/agriculture-banking/miscellaneous-activities/land-purchase-scheme>

2. Ministry of Consumer Affairs, Food & Public Distribution (Department of Food and Public Distribution)



Name of the Scheme:

1. Antyodaya Anna Yojana AAY is one of the public distribution system schemes in India implemented from 2000.

Brief details of the Scheme:

It is to ensure food security and to create hunger-free India. AAY scheme covers the poorest of the poor in India by supply of food and other important commodities for their daily needs on subsidized rates.

Eligibility:

1. Family members falling under Below Poverty line.
2. Annual income of Rs.15000 below families.
3. Disabled persons.
4. Widows and senior citizen of 60 years who heading a family.
5. Tribal families in the rural and mountain areas are eligible for this scheme.

Entitlements:

All beneficiaries under AAY scheme will get food and other important commodities for daily needs in subsidized process. Distribution of food grains to beneficiary will be done through public distribution system.

Under AAY scheme wheat will be provided for Rs.3 per Kg and Rice will be given for Rs.2 per Kg. Eligible family will get 35 Kg of rice per month. AAY families can buy 1 kg of sugar at a rate for Rs. 18.50 per kg via ration shop.

Whether PLHIV are included?

Extended the benefits of AAY (Food Grains) under Targeted Public Distribution System to People Living with HIV in subsidized price.

Source:

<https://dfpd.gov.in/writereaddata/Portal/Magazine/9proc.pdf>

Name of the Scheme:

2. Annapurna Scheme

Brief details of the Scheme:

The scheme aims at providing food security to meet the requirement of those Senior Citizens who though eligible have remained uncovered under the National Old Age Pension Scheme (NOAPS)

Eligibility:

- a) The age of the applicant (male or Female) should be 65 years or above.
- b) The applicant must be destitute in the sense of having little or no regular means of subsistence from his/her own source of income or through financial support from family members or other sources. In order to determine destitution, the criteria (if any) currently in force in the State/UTS could also be followed. c) The applicant should not be in receipt of pension under the NOAPS or State Pension Scheme.
- d) As mentioned above, the Beneficiary would be entitled for 10 Kgs of food grains (wheat or rice) per month free of cost.

Entitlements:

10 Kg. of food grains per month are to be provided 'free of cost' to the beneficiary

Whether PLHIV are included?

Extend the benefits of food grains under Targeted Public Distribution System to People Living with HIV.

Source:

<http://india.gov.in/govt/viewscheme.php?schemeid=426>

3. Ministry of Child and Women Development



Name of the Scheme:

1. The Integrated Child Development Services (ICDS)

Brief details of the Scheme:

ICDS programme is one of the largest national flagship programmes for the development of the maternal and childcare services. Started by the GOI in 1975, operational for over 35 years, it is contributory in improving the health and well-being of maternal and child care through its services. As the restructuring of the ICDS has taken a mission mode, it is considered irreplaceable to include nutrition education, as a component because enhanced nutrition care requires continued and repetitive distinctive actions.

Eligibility:

1. Children (6 months to 72 months)
2. Pregnant and Lactating mothers
3. Severely Malnourished Children (SAM) (6 months to 72 months)

Entitlements:

The ICDS Scheme offers a package of six services

1. Supplementary Nutrition
2. Pre-school non-formal education
3. Nutrition & Health education
4. Immunisation
5. Health Check-ups
6. Referral Services

Whether PLHIV are included?

Double Nutrition support is provided for Children of PLHIV and Children living with HIV.

Source:

<http://icds-wcd.nic.in/icds.htm>

Name of the Scheme:

2. Saksham or Rajiv Gandhi Scheme for Empowerment of Adolescent Boys

Brief details of the Scheme:

It mainly seeks to enable the overall development of youngsters, to make them self-dependent, gender-sensitive, and aware citizens. It will also help them deal with gender violence, and harness their power for the nation-building. The principal aim is to motivate adolescent boys to change their mindsets and let them understand how women are important in societies and why should they be respected to sustain womanhood. It is one sort of training and motivation through awareness campaigns to educate adolescent boys for a brighter India in the future.

Eligibility:

1. This scheme applies to teenage boys ages between 11 to 18 years.
2. The age group has further divided as 11 to 14, and 14 to 18.
3. It will benefit around 6 lakh adolescent boys every year.

Entitlements:

1. This scheme will address the needs of adolescent boys, (both the school-going and outside of the school).
2. It will help them to address their various health needs - mental, physical, and emotional in an efficient manner.
3. Initially, it will be administered in 20 districts across 7 States.
4. It will also offer career skills to the boys above 16, through NSDP (National Skill Development Program).
5. It will spread the awareness of nutrition, cleanliness, sexual, & generative health among teenage boys.
6. Along with the life skills education and public services information.
7. Ministry of Labour & Employment had already chosen the Vocational Service Providers under NSPD. Now, these providers will support the 'Saksham scheme' for providing career training.
8. 'Saksham' will utilize the structures made under ICDS (Integrated Child Development Services Scheme).
9. Dedicated 'Saksham' units/cells will be formed at the Center, each State, districts, and blocks.
10. The Anganwadi centers are the central points to deliver the services, and if the Anganwadi infrastructure is inadequate, they will use panchayat halls, community centers, or schools.

Source:

https://wcd.nic.in/sites/default/files/24-05010215_wcdmedia.pdf

Name of the Scheme:

3. Rajiv Gandhi Scheme for Empowerment of Adolescent Girls: Sabla

Brief details of the Scheme:

1. Enable adolescent girls' self-development and empowerment
2. Improve their nutrition and health status
3. Promote awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and child care
4. Upgrade home-based skills, life skills and integrate with the National Skill Development Program (NSDP) for vocational skills
5. Mainstream out of school adolescent girls into formal/non-formal education.
6. Provide information/guidance about existing public services such as PHC, CHC, post office, bank, police station, etc.

Eligibility:

The program would cover adolescent girls (only covered out of school girls) 11-18 years old under all Integrated Child Development Services projects in 200 selected districts in all states and UTs in the country. The target group would be subdivided into 11-15 and 15-18 years of age.

Entitlements:

1. Nutrition provision
2. Iron and folic acid (IFA) supplementation
3. Health check-up and referral services
4. Nutrition and health education (NHE)
5. Counselling/guidance on family welfare, ARSH, child care practices and home management
6. Life skills education and accessing public services
7. Vocational training for girls aged 16 and above under NSDP

Source:

https://wcd.nic.in/sites/default/files/1-SABLAscheme_0.pdf

Name of the Scheme:

4. Sukanya Samridhi Account (Girl Child Prosperity Account)

Brief details of the Scheme:

The scheme was launched by Prime Minister Narendra Modi on 22 January 2015 as a part of the Beti Bachao, Beti Padhao campaign. The scheme currently provides an interest rate of 7.6%^[3] (for Apr-July 2020 quarter) and tax benefits. The account can be opened at any India Post office or branch of authorised commercial banks. The scheme encourages parents to build a fund for the future education and marriage expenses for their female child

Eligibility:

For the child (account holder)

Only a girl child can open this account.

The maximum age of this child should be 10 years. However a grace period of 1 year is granted.

For the parents

Only biological parents or legal guardians of the child can open the account on the child's behalf. One parent or legal guardian can open up to two accounts for their girl children. In case of twins or triplets the parent or legal guardian can open up to three accounts.

Entitlements:

A minimum of 250 must be deposited in the account initially. Thereafter, any amount in multiples of Rs 100 can be deposited. However, the maximum deposit limit is ₹150,000. If the minimum deposit of ₹250, (initially which was 1000) is not made in a year, a fine of ₹50 will be put on.

The girl can operate her account after she reaches the age of 10. The account allows 50% withdrawal at the age of 18 for higher education purposes. The account reaches maturity after time period of 21 years from date of opening it. Deposits in the account can be made till the completion of 15 years, from the date of the opening of the account. After this period the account will earn only applicable rate of interest. If the account is closed, then it will not earn interest at the prevailing rate. If the girl is over 18 and married, normal closure is allowed.

Source:

http://www.nsiindia.gov.in/InternalPage.aspx?Id_Pk=89

Name of the Scheme:

5. Support to training and employment programme for women (STEP)

Brief details of the Scheme:

This scheme aims to provide skills that give employability to women and to provide competencies and skill that enable women to become self-employed/entrepreneurs. The scheme is intended to benefit women who are in the age group of 16 years and above across the country.

Eligibility:

Women who are in the age group of 16 years and above.

Entitlements:

The assistance under STEP Scheme will be available in any sector for imparting skills related to employability and entrepreneurship, including but not limited to the agriculture, horticulture, food processing, handlooms, tailoring, stitching, embroidery, zari etc., handicrafts, computer & it enable services along with soft skills and skills for the work place such as spoken english, gems & jewellery, travel & tourism, hospitality.

Source:

https://www.startupindia.gov.in/content/sih/en/government-schemes/support_to_training_and_employment_programme.html

Name of the Scheme:

6. Short Stay Homes for women

Brief details of the Scheme:

To provide temporary shelter and support to women and girls who have no social support systems to rely on.

To rehabilitate the women and girls socially and economically by provision of skill training, counselling.

Eligibility:

Those who, as a result of family tension or discord, are made to leave their homes without any means of subsistence and have no Social Protection from exploitation and/or are facing litigation on account of marital disputes.

Those who escape from their homes due to family problems. Girls, between the age group of 15 to 35 years to be given preference.

Children accompanying the mother or born in the Institution may be permitted to stay in the home only upto the age of 6 years, after which they may be transferred to children's institutions or provided foster care facilities. Also, women who have been forced into prostitution, homeless, sexually assaulted, victims of mal-adjustment are eligible to stay in these homes.

Entitlements:

The services extended in these homes include counselling, medical care, psychiatric treatment, occupational therapy, education-cum-vocational training and recreational facilities.

Source:

<http://www.wcddel.in/WEC11.html>

Name of the Scheme:

7. Swadhar Greh

Brief details of the Scheme:

The Swadhar Greh scheme is targeted to provide institutional support to women victims of difficult circumstances and rehabilitate them so that they could lead their life with dignity. The scheme envisages providing shelter, food, clothing and health as well as economic and social security for these women. The scheme envisions a supportive institutional framework for women victims of difficult circumstances so that they could lead their life with dignity and conviction. It also envisions that the special needs of these women are properly taken care of and under no circumstances they should be left unattended or abandoned which could lead to their exploitation and desolation.

Eligibility:

Women above 18 years of age of the following categories:

- Women who are deserted and are without any social and economic support;
- Women survivors of natural disasters who have been rendered homeless and are without any social and economic support;
- Women prisoners released from jail and are without family, social and economic support;
- Women victims of domestic violence, family tension or discord, who are made to leave their homes without any means of subsistence and have no special protection from exploitation and/or facing litigation on account of marital disputes; and
- Trafficked women/girls rescued or runaway from brothels or other places where they face exploitation and Women affected by HIV/AIDS who do not have any social or economic support.

Women affected by domestic violence could stay up to one year. For other categories of women, the maximum period of stay could be up to 3 years. The older women above the 55 years of age may be accommodated for maximum period of 5 years after which they will have to shift to old age homes or similar institutions.

Swadhar Greh facilities could also be availed by the children accompanying women in the above categories, girls up to the age of 18 years and boys up to the age of 8 years would be allowed to stay in the Swadhar Greh with their mothers. (Boys of more than 8 years of age need to be shifted to the Children Homes run under JJ Act/ICPS.)

Entitlements:

1. Temporary residential accommodation with the provision of food, clothing, medical facilities etc.
2. Vocational and skill upgradation trainings for economic rehabilitation of such women
3. Counselling, awareness generation and behavioural trainings
4. Legal aid and Guidance
5. Counselling through telephone

Source:

<https://transformingindia.mygov.in/scheme/swadhar/#:~:text=Introduction%20Check%20Eligibility>

Name of the Scheme:

8. Integrated Child Protection Scheme (ICPS)

Brief details of the Scheme:

The Integrated Child Protection Scheme (ICPS) is a centrally sponsored scheme aimed at building a protective environment for children in difficult circumstances, as well as other vulnerable children, through Government-Civil Society Partnership.

Eligibility:

Adolescent girls in the age group of 11-18 years

Entitlements:

1. Strengthened prevention of child rights violation;
2. Enhanced infrastructure for protection services;
3. Provided financial support for implementation of the Juvenile Justice (Care and Protection of Children) Act, 2000;
4. Increased access to a wider range and better quality of protection services;
5. Increased investment in child protection and is continuously drawing focus on the right of all children to be safe.

Source:

<https://wcd.nic.in/integrated-child-protection-scheme-ICPS#:~:text=The%20Integrated%20Child%20Protection%20Scheme,through%20Government%20Civil%20Society%20Partnership>

Name of the Scheme:

9. Ujjawala Scheme

Brief details of the Scheme:

It is a Comprehensive Scheme for Prevention of Trafficking and Rescue, Rehabilitation, Re-integration and Repatriation of Victims of Trafficking for Commercial Sexual Exploitation.

Eligibility:

1. Women and children who are vulnerable to trafficking for commercial sexual exploitation.
2. Women and children who are victims of trafficking for commercial sexual exploitation.

The implementing agencies must fulfill the below mentioned eligibility conditions:

- The organization should be registered under the law and must have a managing body with its powers and functions clearly in sync with the guidelines and framework laid down in the Constitution for such bodies.
- The agency should not have the primary motive of gaining profit from any individual or group
- Minimum of 3 years of experience is a must post-registration of the organization
- The organization should be financially sound with proper availability of resources and experienced personnel to handle delicate issues.

Entitlements:

These rehabilitative centres are given financial support for providing shelter and basic amenities such as food, clothing, medical care, legal aid; education in the case the victims are children, as well as for undertaking vocational training and income generation activities to provide the victims with alternate livelihood option.

Source:

<https://wcd.nic.in/schemes/ujjawala-comprehensive-scheme-prevention-trafficking-and-rescue-rehabilitation-and-re>

Name of the Scheme:

10. Balika Samridhi Yojana (BSY)

Brief details of the Scheme:

Balika Samridhi Yojana was introduced by the Indian Government in 1997 under the policies for Women and Child Development to facilitate the girl child. It is widely known as a key initiative to support the birth and education of the girl child.

Eligibility:

- Both the rural and urban areas in all the districts of India.
- For the residents of rural areas, families identified to be below the poverty line according to the criteria specified under Swarnajayanti Gram Swarozgar Yojana.
- For the residents of urban areas, the families living in urban slums irrespective of their recognition,
 - families working as:
 - rag-pickers,
 - vegetables & fruit sellers,
 - pavement vendors etc.
- Girl children born on or after 15th August 1997, belonging to families under the poverty line.
- All the benefits of this scheme are provided to only two girl children from every family irrespective of the number of children in the family.

Entitlements:

Rs.500/- presented as a post birth grant amount.

Annual Scholarships for the girl children born on or after 15th August 1997 and are registered under the BSY.

Source:

<https://www.india.gov.in/Balika-Samriddhi-Yojana-ministry-women-and-child-development>

Name of the Scheme:

11. Pradhan Mantri Matru Vandana Yojana (PMMVY)

Brief details of the Scheme:

The scheme was launched in the year 2017 to provide monetary compensation to pregnant women who have lost their job owing to the pregnancy. This scheme also aims to improve the nutrition quotient for pregnant women and lactating mothers.

Eligibility:

1. All Pregnant Women (PW) and Lactating Mothers (LM), excluding PW&LM who are in regular employment with the Central Government or the State Governments or PSUs or those who are in receipt of similar benefits under any law for the time being in force.
2. All eligible Pregnant Women and Lactating Mothers who have their pregnancy on or after 01.01.2017 for first child in family.

Entitlements:

1. Cash incentives in three installments i.e. first installment of Rs. 1000/- on early registration of pregnancy at the Anganwadi Centre (AWC)/ approved Health facility as may be identified by the respective administering State/ UT, second installment of Rs. 2000/- after six months of pregnancy on receiving at least one ante-natal check-up (ANC) and third installment of Rs. 2000/- after child birth is registered and the child has received the first cycle of BCG, OPV, DPT and Hepatitis-B, or its equivalent/ substitute.
2. The eligible beneficiaries would receive the incentive given under the Janani Suraksha Yojana (JSY) for Institutional delivery and the incentive received under JSY would be accounted towards maternity benefits so that on an average a woman gets Rs. 6000/-.

Source:

<http://www.wcddel.in/PMMVY.html>

Name of the Scheme:

12. National Creche Scheme (earlier named as Rajiv Gandhi National Creche Scheme)

Brief details of the Scheme:

It is centrally Sponsored Scheme through States/UTs with effect from 1.1. 2017 to provide day care facilities to children (age group of 6 months to 6 years) of working mothers.

Eligibility:

Day care facilities to children (age group of 6 months to 6 years) of working mothers.

Entitlements:

1. Daycare Facilities including Sleeping Facilities.
2. Early Stimulation for children below 3 years and pre-school Education for 3 to 6 years old children.
3. Supplementary Nutrition (to be locally sourced)
4. Growth Monitoring
5. Health Check-up and Immunization
6. Daycare Facilities including Sleeping Facilities.
7. Early Stimulation for children below 3 years and pre-school Education for 3 to 6 years old children.
8. Supplementary Nutrition (to be locally sourced)
9. Growth Monitoring

Source:

[https://pib.gov.in/PressReleaselframePage.aspx?PRID=1606292#:~:text=National%20Creche%20Scheme%20\(earlier%20named,6%20years\)%20of%20working%20mothers.](https://pib.gov.in/PressReleaselframePage.aspx?PRID=1606292#:~:text=National%20Creche%20Scheme%20(earlier%20named,6%20years)%20of%20working%20mothers.)



4. Indian Railways and State Transport Departments

Name of the Scheme:

1. **Travel Concession (both Rail and Bus) for PLHIV on Anti Retro Viral Treatment (ART).**

Brief details of the Scheme:

ART Centres were located in medical colleges & district Hospitals. Patients from periphery and interiors had to travel long distances to reach the ART centres. In order to improve the levels of adherence to ART, special initiatives like dispensing ARV drugs for 2 months to reduce the number of visits to the ART centre and liaising with concerned ministries to provide concession in rail and bus travel.

Eligibility:

People Living With HIV (PLHIV) on ART

Entitlements:

Fifty percent to seventy five or full concession on bus travel. Fifty percent concession in trains for PLHIV under ART treatment. Boat pass in Andaman and Nicobar Islands.

Whether PLHIV are included?

Exclusive Scheme

Source:

Government orders / circulars on HIV sensitive Social Protection issued by State Governments.

<http://www.naco.gov.in/sites/default/files/Social%20Protection%20Compendium.pdf>



5. National Social Assistance Programme (NSAP)

Name of the Scheme:

1. Indira Gandhi National Widow Pension Scheme (IGNWPS)

Brief details of the Scheme:

Under this pension of Rs. 300 per month to widowed women in BPL category and above 40 years of age is provided.

Eligibility:

- Widowed women in BPL category above 40 years of age.
- All most all states have waived off the age barrier in case of PLHIV widow.

Entitlements:

Rs. 300 per month per beneficiary between 40-79 years. 500 after 80 years of age. However, in Assam for a PLHIV widow, one time amount of one lakh is given.

Whether PLHIV are included?

Age relaxation was provided to widows of PLHIV.

Source:

<http://www.nari.nic.in/schemes/Indira-Gandhi-national-widow-pension-scheme#:~:text=The%20Indira%20Gandhi%20National%20Widow,500%20per%20month.>

Name of the Scheme:

2. National Family Benefit Scheme (NFBS)

Brief details of the Scheme:

This scheme is aimed to support BPL families. The NFBS provides a lumpsum family benefit of Rs. 10000 to the bereaved household in case of death of the primary bread winner irrespective of the cause of death.

Eligibility:

- The bread-winner should have been between 18-64 years of age.

Entitlements:

In the event of death of a bread-winner in a household, the bereaved family will receive lumpsum assistance of 20,000. The assistance would be provided in every case of death of primary bread-winner in a household.

Whether PLHIV are included?

Yes

Source:

<http://india.gov.in/govt/viewscheme.php?schemeid=112>Name of the Scheme:

Name of the Scheme:

3. Indira Gandhi National Disability Pension Scheme (IGNDPS)

Brief details of the Scheme:

To provide social benefit to the poor household in the case of PWDs Beneficiary: People living Below Poverty Line with the age group of 18-79 years and having 80% and above / multiple disabilities are eligible to get the pension.

Eligibility:

- Individuals aged 18 years and above with more than 80% disability and living below the poverty line.

Entitlements:

This is a Govt. of India funded Scheme where the beneficiaries receive Rs.300/- per month under this scheme. Central Govt. is providing the entire amount. In addition to this State Govt. is providing Rs.200/- per month to each beneficiaries under IGNDP as all the IGNDP beneficiaries are above 80% disabled /multiple disabled.

Whether PLHIV are included?

Yes

Source:

<https://dhenkanal.nic.in/service/Indira-Gandhi-national-disability-pension-schemeigndps>

Name of the Scheme:

4. Indira Gandhi National Old Age Pension Scheme (IGNOAPS)

Brief details of the Scheme:

The National Social Assistance Programme is a centrally sponsored scheme of the Government of India that provides financial assistance to the elderly, widows and persons with disabilities in the form of social pensions.

Eligibility:

- Indians who are 60 years and above and live below the poverty line

Entitlements:

All IGNOAPS beneficiaries aged 60-79 shall receive a monthly pension of Rs. 300 (Rs. 200 by central government and Rs. 100 by state government). Those 80 years and above receive a monthly pension amount of Rs.500. States are strongly urged to provide an additional amount at least an equivalent amount to the assistance provided by the Central Government so that the beneficiaries can get a decent level of assistance.

Whether PLHIV are included?

Yes

Source:

<https://nsap.nic.in/>



6. National Legal Services Authority (NALSA)

Name of the Scheme:

1. Legal aid Clinics

Brief details of the Scheme:

The State AIDS Control Societies in partnership with State Legal Services Authority set up Legal Aid Clinics (LAC) for PLHIVs to access free legal services in the districts. They are to work towards preventing stigma and discrimination and ensure livelihood rights and opportunities for PLHIVs. The LACs functioned within the coordinated service delivery mechanism of the Legal Services Authority, SACS, district-level network and the district administration.

Eligibility:

PLHIVS

Entitlements:

Addresses all the legal issues including Stigma Discrimination.

Whether PLHIV are included?

Exclusive

Source:

<https://nalsa.gov.in/notifications/2>

7. Ministry of Finance



Name of the Scheme:

1. Pradhan Mantri Jan-Dhan Yojana (PMJDY)

Brief details of the Scheme:

A national mission with an aim to provide access to various financial services including Remittance, Credit, Insurance, Pension, Banking Savings & Deposit Accounts in an affordable manner.

Eligibility:

Every individual who does not have a bank account in India

Entitlements:

1. One basic savings bank account is opened for unbanked person.
2. There is no requirement to maintain any minimum balance in PMJDY accounts.
3. Interest is earned on the deposit in PMJDY accounts.
4. Rupay Debit card is provided to PMJDY account holder.
5. Accident Insurance Cover of Rs.1 lakh (enhanced to Rs. 2 lakh to new PMJDY accounts opened after 28.8.2018) is available with RuPay card issued to the PMJDY account holders.
6. Life Insurance Cover of Rs. 30,000 to eligible PMJDY account holders who opened their account for the first time between 15.8.2014 to 31.1.2015 is available.
7. An overdraft (OD) facility up to Rs. 10,000 to eligible account holders is available.
8. PMJDY accounts are eligible for Direct Benefit Transfer (DBT), Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Atal Pension Yojana (APY), and Micro Units Development & Refinance Agency Bank (MUDRA) scheme.

Whether PLHIV are included?

No

Source:

<https://pmjdy.gov.in/scheme>

Name of the Scheme:

2. Atal Pension Yojana

Brief details of the Scheme:

This scheme replaces the Swavalamban Yojana and was established to provide old age income security to the workers belonging to the unorganised sector.

Eligibility:

1. Atal Pension Yojana (APY) is open to those who are not a member of any statutory social security scheme.
2. Any individual aged between 18 years to 40 years and have a bank account are eligible for the scheme.
3. He/She will have to provide proof of possession along with their Aadhaar number or must undergo Aadhaar authentication.
4. The subscriber should get their Aadhaar number recorded in the APY pension account as well as in their savings account.
5. Providing of the Aadhar number is important for the debit of the contribution instalments and for the credit of government co-contribution.

Entitlements:

1. The scheme provides the subscribers with a fixed pension ranging between Rs. 1000 to Rs. 5000. The pension is provided if he/she joins and contributes between the age of 18 years and 40 years. The contribution level varies as per the conditions which are low if the subscriber joins the scheme early and might increase if he/she joins late.
2. After the death of the subscriber, the spouse is eligible for availing the same benefits provided by the pension.
3. The indicative pension wealth will be returned to the nominees after the death of a spouse.
4. Contributions to the Atal Pension Yojana (APY) is eligible for tax benefits similar to the National Pension System (NPS).

Source:

Regulatory Body Pension Fund Regulatory and Development Authority (PFRDA) Department of Financial Services, Government of India <https://www.npscra.nsdl.co.in/scheme-details.php>

Name of the Scheme:

3. Stand-Up India

Brief details of the Scheme:

The objective is to support entrepreneurship among women and SC & ST communities

Eligibility:

Individual above 18 years of age. The entrepreneur must either be a woman or belong to the SC or ST community.

Entitlements:

The scheme offers bank loans between 10 lakh and 1 crore for scheduled castes and scheduled tribes and women setting up new enterprises outside of the farm sector.

Source:

<https://www.standupmitra.in/Home/SUISchemes>

Name of the Scheme:

4. Pradhan Mantri Suraksha Bima Yojana

Brief details of the Scheme:

This is an insurance scheme for accidental death that was first announced by Finance Minister Arun Jaitley

Eligibility:

Entitlements:

1. It offers a life cover of Rs. 2 lakhs for one year to all its account holders. This life cover is provided in case of accidental death or permanent disability.
2. A life cover of Rs. 1 lakh is provided to the beneficiary in case of partial disability.
3. In case of the death of the account holder, the benefits of the scheme can be availed by his/her nominee.
4. The scheme provides an annual premium of Rs. 12 per annum per member. This premium is auto-debited in one instalment on or before 1st June of every year.

Source:

<https://financialservices.gov.in/>

Name of the Scheme:

5. Aam Aadmi Bima Yojana (AABY)

Brief details of the Scheme:

With the aim of providing social security to occupational groups within the unorganised sector, the Government of India launched the Aam Aadmi Bima Yojana (AABY) in October 2007. It covers natural or accidental death and disability of people who fall within certain occupational groups.

Eligibility:

The beneficiary should fulfil the below criteria:

1. Age: The applicant should be between 18 years and 59 years of age.
2. Income: Should belong to rural landless household (RLH) and below poverty line (BPL) family.
3. Members: Only one member of the family is eligible. He/she should be the head of the family or the earning member.
4. Documents: Along with the application form, the applicant has to provide supporting documents such as age proof, identity proof, address proof, and income certificate.

Entitlements:

1. Natural Death: If the insured dies due to natural causes during the policy period, the sum assured of INR 30,000 will be paid to the nominee or surviving members.
2. Accidental Death: Accidents come unannounced. In case of death of the policyholder due to an accident, an amount of INR 75,000 is paid to the surviving beneficiaries or family members.
3. Disability benefits: An accident can, sometimes, cause disability. If the insured suffers from permanent partial disability, he's entitled to coverage of INR 37,500. If the beneficiary suffers from permanent total disability, the claim amount is INR 75,000.
4. Scholarship benefits: Apart from providing death and disability benefits, the Aam Aadmi Bima Yojana also offers a scholarship of INR 100 per child per month. The scholarship will be given to a maximum of two children of the beneficiary studying between 9 to 12th standard.

Source:

<http://bor.up.nic.in/aabyaudit/>

Name of the Scheme:

6. Pradhan Mantri Mudra Yojana (PMMY)

Brief details of the Scheme:

Micro Units Development and Refinance Agency (which is MUDRA full form) Loan scheme under Pradhan Mantri Mudra Yojana (PMMY) is an initiative by Government of India that offers loans to individuals, SMEs and MSMEs. MUDRA loan is offered under 3 loan schemes named as Shishu, Kishor, and Tarun. The maximum loan amount offered under MUDRA scheme is up to Rs. 10 lakh, whereas there is no minimum loan amount criterion. No collateral or security is required by banks or financial institutions to avail Mudra loan. The repayment tenure of Mudra loan ranges from 3 years to 5 years with flexible EMI options.

Eligibility:

- Individuals,
- SMEs,
- MSMEs,
- Enterprises or businesses engaged in Manufacturing, Trading and Services Sectors.

Entitlements:

1. Mudra loans are majorly offered to shopkeepers, traders, vendors, and MSMEs engaged in manufacturing, trading and service sector activities
2. Mudra scheme is covered under Credit Guarantee Schemes from Govt. of India
3. Availed loan amount can also be used as term loans and overdraft facilities
4. All Non-farm enterprises, i.e. small or micro firms engaged in the income generating activities can avail Mudra loan
5. Mudra scheme can be availed via Mudra cards, as well.

Products offered under Mudra Scheme are classified under 3 loan schemes named as Shishu, Kishor and Tarun.

1. SHISHU Loan: Loans up to Rs. 50,000 (For start-ups and new businesses)
2. KISHOR Loan: Loans from Rs. 50,001 to Rs. 5,00,000 (For buying equipment/ machinery, raw materials, business expansion for existing enterprises)
3. TARUN Loan: Loans from Rs. 500,001 to Rs. 10,00,000 (For established businesses and enterprises)

Whether PLHIV are included?

No

Source:

<https://www.mudra.org.in/>



8. Ministry of Labour and Employment

Name of the Scheme:

1. Rashtriya Swasthya Bima Yojana (RSBY)

Brief details of the Scheme:

Government of India to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. The majority of the financing, about 75 percent, is provided by the Government of India (GOI), while the remainder is paid by the respective state government. Government of India's contribution is 90 percent in case of North-eastern states and Jammu and Kashmir and respective state Governments need to pay only 10% of the premium. Beneficiaries need to pay only Rs. 30 as the registration fee. This amount shall be used for incurring administrative expenses under the scheme.

Eligibility:

1. Unorganized sector workers belonging to BPL category and their family members (a family unit of five)

Entitlements:

1. The unorganised sector worker and his family (unit of five) will be covered.
2. Total sum insured would be Rs. 30,000/- per family per annum on a family floater basis.
3. Cashless attendance to all covered ailments
4. Hospitalization expenses, taking care of most common illnesses with as few exclusions as possible
5. All pre-existing diseases to be covered
6. Transportation costs (actual with maximum limit of Rs. 100 per visit) within an overall limit of Rs. 1000.

Whether PLHIV are included?

NACO encourages enrollment of PLHIV. However, very few Insurance products are available for PLHIV. It may be noted that private sector has already launched a scheme for the HIV+ patients. A mediclaim policy exclusively for those suffering from HIV was launched in Karnataka.

Source:

<https://www.india.gov.in/spotlight/rashtriya-swasthya-bima-yojana>

9. Ministry of Skill Development and Entrepreneurship



Name of the Scheme:

1. Pradhan Mantri Kaushal Vikas Yojana

Brief details of the Scheme:

The aim of the PMKVY scheme is to encourage aptitude towards employable skills and to increase working efficiency of probable and existing daily wage earners, by giving monetary awards and rewards and by providing quality training to them. Average award amount per person has been kept as ₹8,000. Those wage earners already possessing a standard level of skill will be given recognition as per scheme and average award amount for them is ₹2000 to 2500. In the initial year, a target to distribute ₹15 billion has been laid down for the scheme. Training programmes have been worked out on the basis of National Occupational Standards (NOS) and qualification packs specifically developed in various sectors of skills. For this qualification plans and quality plans have been developed by various Sector Skill Councils (SSC) created with participation of Industries.

Eligibility:

1. An Indian national with a valid identity proof like a voter's ID, Aadhaar card or a bank account
2. An unemployed youth or should have dropped out of college or school midway through the academic tenure

Entitlements:

1. The scheme offers cost-free, industry-related skills training to unemployed youth and school or college dropouts to make them fit for employment
2. The scheme offers valid certification and a Skill India card basis which the candidates can apply for jobs and earn a livelihood
3. The scheme offers financial and placement assistance to candidates who have been awarded a certificate
4. The scheme also offers training to the youth with prior experience so as to bridge the gap between their skills and industrial requirements
5. The scheme contributes to the country's economic development by creating a skilled workforce.

Source:

<http://www.pmkvyofficial.org/>

Note: The Ministry of Skill Development and Entrepreneurship is responsible for the Skill India initiative. This initiative consists of:

1. National Skill Development Mission
2. Pradhan Mantri Kaushal Vikas Yojana (PMKVY)
3. National Policy for Skill Development and Entrepreneurship 2015
4. Skill Loan Scheme

10. Ministry of Education



Name of the Scheme:

1. Mid-day Meal Scheme

Brief details of the Scheme:

It is a school meal programme of the Government of India designed to better the nutritional standing of school-age children nationwide. The programme supplies free lunches on working days for children in primary and upper primary classes in government, government aided, local body, Education Guarantee Scheme, and alternate innovative education centres, Madarsa and Maqtabs supported under Sarva Shiksha Abhiyan, and National Child Labour Project schools run by the ministry of labour.

Eligibility:

- Children studying in Primary and Upper Primary Classes in Government, Govt. Aided, Local Body, EGS and AIE Centres, Madarsa and Maqtabs supported under Sarva Shiksha Abhiyan and NCLP Schools run by Ministry of Labour.

Entitlements:

Mid-Day Meal Scheme aims to:

1. Avoid classroom hunger.
2. Increase school enrolment.
3. Increase school attendance.
4. Improve socialisation among castes.
5. Address malnutrition.
6. Empower women through employment.

The scheme guidelines envisage to provide cooked mid-day meal with 450 calories and 12 g of protein to every child at primary level and 700 calories and 20 g of protein at upper primary level. This energy and protein requirement for a primary child comes from cooking 100 g of rice/flour, 20 g pulses and 50 g vegetables and 5 g oil, and for an upper primary child it comes from 150 g of rice/flour, 30 g of pulses and 75 g of vegetables and 7.5 g of oil.

The present provisions are as given below:-

1. Free supply of food grains @ 100 grams per child per school day at Primary and @ 150 grams per child per school day at Upper Primary.
2. Subsidy for transportation of food grains is provided to 11 special category states at PDS rate prevalent in these states and up to a maximum of Rs.75.00 per quintal for other than special categories States/UTs
3. In addition to food grains, a mid day meal involves major input, viz. cost of cooking, which is explained below. Cost of cooking includes cost of ingredients, e.g. pulses, vegetables, cooking oil and condiments. In order to cover the impact of price rise in the items of consumption in the MDM basket, the cooking cost has been revised upward annually since 2010.

Whether PLHIV are included?

Yes

Source:

http://mdm.nic.in/mdm_website/

11. National Health Mission (NHM), MOH&FW



Name of the Scheme:

1. Janani Suraksha Yojana (JSY)

Brief details of the Scheme:

It is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW ((Anganwadi workers)and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

Eligibility:

- Poor pregnant woman with special dispensation for states having low institutional delivery rates.
- Pregnant women who have attained 19 years of age and belong to the below poverty line (BPL) households.

Entitlements:

1. Tracking Each Pregnancy: Each beneficiary registered under this Yojana should have a JSY card along with a MCH card. ASHA/AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should mandatorily prepare a micro-birth plan. This will effectively help in monitoring Antenatal Check-up, and the post-delivery care.
2. Eligibility for Cash Assistance: BPL Certification - This is required in all HPS states. However, where BPL cards have not yet been issued or have not been updated, States/UTs would formulate a simple criterion for certification of poor and needy status of the expectant mother's family by empowering the gram Pradhan or ward member.

Disbursement of Cash Assistance: As the cash assistance to the mother is mainly to meet the cost of delivery, it should be disbursed effectively at the institution itself.

For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her in one go, at the health institution. Considering that some women would access accrediting private institution for antenatal care, they would require some financial support to get at least 3 ANC's including the TT injections. In such cases, at least three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go, importantly, at the time of delivery.

Whether PLHIV are included?

Yes

Source:

https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg

Name of the Scheme:

2. Revised National TB Control Programme (RNTCP)

Brief details of the Scheme:

Tuberculosis (TB) control activities are implemented in the country for more than 50 years. The National TB Programme (NTP) was launched by the Government of India in 1962 in the form of District TB Centre model involved with BCG vaccination and TB treatment. In 1978, BCG vaccination was shifted under the Expanded Programme on Immunisation. RNTCP has released a 'National strategic plan for tuberculosis 2017-2025' (NSP) for the control and elimination of TB in India by 2025. According to the NSP TB elimination have been integrated into the four strategic pillars of "Detect - Treat - Prevent - Build" (DTPB).

Eligibility:

- All drug sensitive TB cases (DS-TB) and
- Drug resistant TB cases (DRTB) with an emphasis on reaching TB patients seeking care from private providers and
- Undiagnosed TB cases in high-risk populations, such as:
 - Prisoners,
 - Migrant workers,
 - People living with HIV/AIDS, contacts

Entitlements:

For all HIV infected children who either had a known exposure to an infectious TB case or are Tuberculin skin test (TST) positive (≥ 5 mm induration) but have no active TB disease.

Whether PLHIV are included?

Yes

Source:

https://www.nhp.gov.in/revised-national-tuberculosis-control-programme_pg

Name of the Scheme:

3. National Maternity Benefit Scheme (NMBS)

Brief details of the Scheme:

The NMBS, launched in 1995, is aimed at providing better care to pregnant mothers of poor households by providing financial assistance of Rs 500 for first two births. The scheme was later sought to be discontinued in 2005 by replacing it with JSY. In its affidavit filed before the Bench of Justice Arijit Prasayat and 5 H Kapadia, the Centre said that the NMBS will continue and its coverage will be further widened by doing away with restrictions on number of children and age of the mother. Earlier, the scheme's coverage was limited to two births for mothers of 19 years and above.

Eligibility:

- Women belonging to poor households for pre-natal and post-natal maternity care upto first two live births.
- Eligible women of 19 years and above.

Entitlements:

Financial assistance of Rs 500 for first two births

Whether PLHIV are included?

Yes

Source:

https://niti.gov.in/planningcommission.gov.in/docs/reports/sereport/ser/maker/mak_cht5c.pdf

Name of the Scheme:

4. Pradhan Mantri Jan Arogya Yojana (PM-JAY)

Brief details of the Scheme:

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana of the Government of India to provide free access to healthcare for 40% of people in the country. People using the program access their own primary care services from a family doctor.

Eligibility:

- 1) Those living in scheduled caste and scheduled tribe households
- 2) Families with no male member aged 16 to 59 years
- 3) Beggars and those surviving on alms
- 4) Families with no individuals aged between 16 and 59 years
- 5) Families having at least one physically challenged member and no able-bodied adult member
- 6) Landless households who make a living by working as casual manual labourers
- 7) Primitive tribal communities
- 8) Legally released bonded labourers

- 9) Families living in one-room makeshift houses with no proper walls or roof
- 10) Manual scavenger families In the urban areas, those who can avail of the government-sponsored scheme consist mainly of:
 1. Washerman / chowkidars
 2. Rag pickers
 3. Mechanics, electricians, repair workers
 4. Domestic help
 5. Sanitation workers, gardeners, sweepers
 6. Home-based artisans or handicraft workers, tailors
 7. Cobblers, hawkers and others provide services by working on streets or pavements
 8. Plumbers, masons, construction workers, porters, welders, painters and security guards
 9. Transport workers like drivers, conductors, helpers, cart or rickshaw pullers
 10. Assistants, peons in small establishments, delivery boys, shopkeepers and waiters

Entitlements:

PMJAY helps household's access secondary and tertiary care via funding of up to Rs. 5 lakh per family, per year. This assistance is valid for day care procedures and even applies to pre-existing conditions. PMJAY extends coverage for over 1,350 medical packages at empanelled public and private hospitals.

Some of the Critical illnesses that are covered are as follows.

1. Prostate cancer
2. Coronary artery bypass grafting
3. Double valve replacement
4. Carotid angioplasty with stent
5. Pulmonary valve replacement
6. Skull base surgery
7. Laryngopharyngectomy with gastric pull-up
8. Anterior spine fixation
9. Tissue expander for disfigurement following burns

PMJAY has a minimal list of exclusions. They are as follows.

1. OPD
2. Drug rehabilitation programme
3. Cosmetic related procedures
4. Fertility related procedures
5. Organ transplants
6. Individual diagnostics (for evaluation)

Source:

<https://pmjay.gov.in/>

12. Ministry of Housing and Urban Affairs



Name of the Scheme:

1. Deendayal Antyodaya Yojana-National Urban Livelihoods Mission (DAY-NULM)

Brief details of the Scheme:

To reduce poverty and vulnerability of the urban poor households by enabling them to access gainful self-employment and skilled wage employment opportunities, resulting in an appreciable improvement in their livelihoods on a sustainable basis, through building strong grassroots level institutions of the poor. The mission would aim at providing shelters equipped with essential services to the urban homeless in a phased manner. In addition, the mission would also address livelihood concerns of the urban street vendors by facilitating access to suitable spaces, institutional credit, social security and skills to the urban street vendors for accessing emerging market opportunities. The scheme is integration of the National Urban Livelihoods Mission (NULM) and National Rural Livelihoods Mission (NRLM).

Eligibility:

- Urban poor
- Urban homeless
- Urban street vendors

Entitlements:

1. Employment through Skill Training and Placement – An expenditure of Rs.15, 000 per person is allowed on training of urban poor which is Rs. 18, 000 in North-East and J&K. Moreover, Training urban poor to meet the enormous demand from urban citizens by imparting market-oriented skills through City Livelihood Centers.
2. Social Mobilization and Institution Development – It will be done through formation of Self-Help Groups (SHG) for training members and hand holding, an initial support of 10, 000 is given for each group. Assistance of Rs.50, 000 is provided to Registered Area Level Federations.
3. Subsidy to urban poor – An interest subsidy of 5% 7% for setting up individual micro-enterprises with a loan of up to 2 lakh and for group enterprises with a loan limit of up to Rs.10 lakhs.
4. Shelters for urban homeless – Cost of construction of shelters for urban homeless is fully funded under the Scheme.
5. Other means – Development of vendor markets and also the promotion of skills for the vendors through setting up infrastructure and special projects for the rag picker and differently abled etc.

Whether PLHIV are included?

Yes

Source:

<http://nulm.gov.in/>

Name of the Scheme:

2. Swarna Jayanti Shahari Rozgar Yojana (SJSRY)

Brief details of the Scheme:

The scheme aims to provide gainful employment to the urban unemployed or underemployed poor through encouraging the setting up of self-employment ventures or provision of wage employment. This programme will rely on creation of suitable community structures on the UBSP pattern and delivery of inputs under this programme shall be through the medium of urban local bodies and such community structures. It consist of two special schemes, namely-

- (i) The Urban Self Employment Programme (USEP)
- (ii) The Urban Wage Employment Programme (UWEP)

Eligibility:

- Urban poor, defined as those living below the urban poverty line.
- Women, persons belonging to Scheduled Castes/ Tribes, disabled persons and other such. categories
- A special provision of 3% reserved for the disabled

Entitlements:

Under the Urban Self Employment Programme (USEP):

1. Assistance to individual urban poor beneficiaries for setting up gainful self-employment ventures.
2. Assistance to groups of urban poor women for setting up gainful self-employment ventures. This sub-scheme may be called “The Scheme for Development of Women and Children in the Urban Areas (DWCUA)”.
3. Training of beneficiaries, potential beneficiaries and other persons associated with the urban employment programme for up gradation and acquisition of vocational and entrepreneurial skills.

Under the Urban Wage Employment Programme (UWEP):

Provide wage employment to beneficiaries living below the poverty line within the jurisdiction of urban local bodies by utilising their Labour for construction of socially and economically useful public assets. This programme shall apply to urban local bodies, the population of which was less than 5 lakhs as per the 1991 Census. This programme shall be dove tailed with the State sector EIUS scheme as well as the NSDP This programme is not designed to either replace or substitute the EIUS, the NSDP, or any other State sector schemes.

Whether PLHIV are included?

Yes

Source:

[http://mohua.gov.in/upload/uploadfiles/files/7\(3\).pdf](http://mohua.gov.in/upload/uploadfiles/files/7(3).pdf)



13. Ministry of Housing and Urban Poverty Alleviation

Name of the Scheme:

1. **Rajiv Awas Yojana (RAY) or Pradhan Mantri Awas Yojana (PMAY)**

Brief details of the Scheme:

It is an initiative by Government of India in which affordable housing will be provided to the urban poor with a target of building 20 million affordable houses by 31 March 2022. It has two components: Pradhan Mantri Awas Yojana (Urban) (PMAY-U) for the urban poor and Pradhan Mantri Awas Yojana (Gramin) (PMAY-G and also PMAY-R) for the rural poor. This scheme is converged with other schemes to ensure houses have a toilet, Saubhagya Yojana electricity connection, Ujjwala Yojana LPG gas connection, access to drinking water and Jan Dhan banking facilities, etc.

Eligibility:

1. Beneficiary max age 70 years
2. EWS (Economic Weaker Section) family income limit is ₹3 Lakhs per annum and for LIG (Lower Income Group) Family Income limit is 6 Lakhs per annum, and Middle Income Group -(MIG-I) income between 6 lakhs to 12 lakhs per annum, (MIG-II) income between 12 lakhs to 18 lakhs per annum
3. The beneficiary should not have an own dwelling unit on the name of any family member in any part of India. 4. The loan applicant should not have availed any central/state government subsidy or benefit for buying a home under the PMAY scheme.
5. Currently, the loan applicant should not own any property under their name and along with any of the family members (including the dependents).
6. The home renovation or improvement loans, self-construction loans will be allocated only for EWS and LIG categories.

Entitlements:

It is proposed to build 2 crore houses for urban poor including Economically Weaker Sections and Low Income Groups in urban areas by the year 2022 through a financial assistance of ₹2 trillion from central government.

Under the Pradhan Mantri Awas Yojana, a subsidy of Rs 2.67 lakh is provided by the government on the interest of home loan for buying a house.

Whether PLHIV are included?

In few select states.

Source:

<http://mohua.gov.in/cms/raji-awasyojana.php>

14. Ministry of Social Justice and Empowerment



Name of the Scheme:

1. Dr. Ambedkar Medical Aid Scheme

Brief details of the Scheme:

The scheme is meant to provide medical treatment facility to the patients suffering from serious ailments requiring surgery of Kidney, Heart, Liver, Cancer and Brain or any other life threatening diseases including Knee surgery and Spinal surgery to Scheduled Caste and Scheduled Tribe persons whose annual family income is less than Rs.1,00,000/- p.a. through select hospitals.

Eligibility:

People from Scheduled Caste and Scheduled Tribe Community.

- Annual family income shall not exceed Rs. 1,00,000/- per annum.
- Those who are suffering from major ailments which need surgery such as kidney, heart, liver, cancer, brain or any other life threatening disease including organ transplant and spinal surgery.

Entitlements:

100% of the estimated cost of the treatment will be directly released to the concerned Hospital, with a maximum ceiling limit of i.e. Heart Surgery Rs. 1.25 lakh, Kidney Surgery/ Dialysis Rs. 3.50 lakh, Cancer Surgery / Chemotherapy / Radiotherapy Rs. 1.75 lakh, Brain Surgery Rs. 1.50 lakh, Kidney/ Organ Transplant Rs. 3.50 lakh, Spinal Surgery Rs. 1.00 lakh and for any other life threatening diseases Rs. 1.00 lakh.

Whether PLHIV are included?

No

Source:

<http://ambedkarfoundation.nic.in/schemes/medi16.pdf>

Name of the Scheme:

2. Scheme of Free Coaching for SC and OBC Students

Brief details of the Scheme:

The objective of the Scheme is to provide coaching of good quality for economically disadvantaged Scheduled Castes (SCs) and Other Backward Classes (OBCs) candidates to enable them to appear in competitive examinations and succeed in obtaining an appropriate job in Public/Private Sector.

The Scheme will be implemented through the reputed coaching institutions/centres run by the: Central Government/State Governments/UT Administrations/PSUs/Autonomous Bodies under Central/State Governments; Universities (both Central and State) including the Deemed Universities and Private Universities recognized by concerned authority; and Registered private institutions/NGOs.

Eligibility:

- Economically disadvantaged Scheduled Castes (SCs) and
- Other Backward Classes (OBCS)

Entitlements:

Group A and B examinations conducted by the Union Public Service Commission (UPSC), the Staff Selection Commission (SSC) and the various Railway Recruitment Boards (RRBs); Group A and B examinations conducted by the State Public Service Commissions; Officers' Grade examinations conducted by Banks, Insurance Companies and Public Sector Undertakings (PSUs);

Premier Entrance Examinations for admission in (a) Engineering (eg. IIT-JEE & AIEEE), (b) Medical (eg. AIPMT), (c) Professional courses like Management (eg. CAT) and Law (eg. CLAT), and (d) Any other such disciplines as Ministry may decide from time to time.

Eligibility tests/examinations like SAT, GRE, GMAT and TOEFL.

Whether PLHIV are included?

In some states, PLHIV children have been included for free coaching.

Source:

<http://socialjustice.nic.in/SchemeList/Send/96?mid=32549>

Name of the Scheme:

3. Assistance to Voluntary Organizations for Prevention of Alcoholism and Substance (Drugs) Abuse and for Social Defence Services

Brief details of the Scheme:

The scheme is in the field of drug demand reduction. The Scheme has two parts viz.

- 1 Assistance for the Prevention of Alcoholism & Substance (Drugs) Abuse
2. Financial Assistance in the Field of Social Defence

The Scheme of 'General Grant-in-Aid Programme for Financial Assistance in the Field of Social Defence' aims to support such initiatives of an innovative/pilot nature in the area of welfare and empowerment of the Ministry's target groups, as cannot be supported under its regular schemes. Financial assistance is given up to 90% of the approved expenditure to the voluntary and other eligible organizations. In case of an organization working in a relatively new area where both voluntary and Government effort is very limited but the need for the service is very great, the Government may bear up to 100% of the cost.

Eligibility:

Under this scheme, financial assistance up to 90% of the approved expenditure is given to the voluntary organizations and other eligible agencies for setting up/running Integrated Rehabilitation Centre for Addicts (IRCA), Regional Resource and Training Centres (RRTC), for holding Awareness-cum-de-addiction camps (ACDC) and Workplace Prevention Programmes etc. In the case of North-Eastern States, Sikkim and Jammu & Kashmir, the quantum of assistance is 95% of the total admissible expenditure. The balance has to be borne by the implementing agency.

Entitlements:

The Scheme of Assistance for the Prevention of Alcoholism and Substance (Drugs) Abuse is being implemented for identification, counselling, treatment and rehabilitation of addicts through voluntary and other eligible organizations.

Source:

<http://socialjustice.nic.in/SchemeList/Send/42?mid=48565>

Name of the Scheme:

4. National Backward Classes Finance and Development Corporation (NBCFDC)

Brief details of the Scheme:

It is to improve and develop the economic activities for the members of Backward Classes who are living below double the poverty line.

Eligibility:

- Members of Backward Classes living below the poverty line.

Entitlements:

The corporation can assist loan for their self-employment ventures in the sectors like agriculture, transport and service etc. NBCFDC also provides Micro Financing through SCAs/ Self Help Groups (SHGs). The corporation can assist a wide range of income generating activities to assist the poorer section of these classes in skill development and self-employment ventures under following broad sectors.

Source:

<https://nbcfdc.gov.in/>

Name of the Scheme:

5. National Scheduled Castes Finance & Development Corporation

Brief details of the Scheme:

It was set up for financing, facilitating and mobilizing funds for the economic empowerment of persons belonging to the Scheduled Castes families living below double the Poverty Line.

Eligibility:

- Persons belonging to the Scheduled Castes families living below the Poverty Line.

Entitlements:

1. Identification of trades & other economic activities of importance to Scheduled Castes population.
2. Upgradation of skills & processes used by persons belonging to Scheduled Castes.
3. Promotion of small, cottage & village industries.
4. Financing of pilot programmes for upliftment and economic welfare of persons belonging to Scheduled Castes.
5. Improvement in flow of financial assistance to persons belonging to Scheduled Castes for their economic well-being.
6. Assistance to target group in setting up their projects by way of project preparation, training and financial assistance.
7. Extending loans to eligible students belonging to Scheduled Castes for pursuing full time professional and technical courses in India and abroad.
8. Extending loans to eligible youth to enhance their skill & employability by pursuing vocational education & training courses in India.

Whether PLHIV are included?

Yes

Source:

<https://nsfdc.nic.in/en/about-nsfdc>

Name of the Scheme:

6. National Portal for Transgender persons

Brief details of the Scheme:

The Portal provides the facility for transgender persons to apply for a certificate and an identity card from across the country without physical interface through a seamless end-to-end mechanism. The Transgender certificate and identity card are nationally recognised and are provided by the Ministry of Social Justice & Empowerment. The certificate is a mandatory document to avail of the welfare measures being provided under the SMILE scheme.

Eligibility:

Any Transgender person.

Entitlements:

The Portal provides the facility for transgender persons to apply for a certificate and an identity card from across the country without physical interface through a seamless end-to-end mechanism. The Transgender certificate and identity card are nationally recognised and are provided by the Ministry of Social Justice & Empowerment. The certificate is a mandatory document to avail of the welfare measures being provided under the SMILE scheme.

Whether PLHIV are included?

Yes

Source:

<https://transgender.dosje.gov.in/>

Name of the Scheme:

7. “SMILE - Support for Marginalized Individuals for Livelihood and Enterprise”

Brief details of the Scheme:

This includes two sub-schemes - Comprehensive Rehabilitation for Welfare of Transgender Persons’ and ‘Comprehensive Rehabilitation of persons engaged in the act of Begging.

Eligibility:

Any Transgender person.

Entitlements:

This umbrella scheme would cover several comprehensive measures including welfare measures for the transgender community and for persons who are engaged in the act of begging with a focus extensively on rehabilitation, provision of medical facilities, counselling, education, skill development, economic linkages etc. with the support of State Governments/UTs/Local Urban Bodies, Voluntary Organizations, Community Based Organizations (CBOs)/Institutions and others.

Financial assistance in the form of scholarships to transgender students studying in classes Ninth till post-graduation, skill development training & livelihood, composite medical health for availing gender reaffirmation surgeries, pre and post-operative procedures and other health care facilities, setting up of Garima Grehs in each state for providing shelter facility for abandoned and orphaned transgender persons.

Whether PLHIV are included?

Yes

Source:

<https://static.pib.gov.in/WriteReadData/specificdocs/documents/2022/mar/doc20223522601.pdf>

15. Ministry of Communication and Information Technology



Name of the Scheme:

1. Gram Priya (Anticipated Endowment Scheme)

Brief details of the Scheme:

Proponent is given an assurance to the extent of Sum Assured with accrued bonus payable till completion of ten years. No interest charged upto one year arrear of premier in case of natural calamities like flood, drought, earthquake, cyclone etc.

Eligibility:

The scheme shall cover all persons, male or female, who permanently reside in rural areas and are ordinarily residents in India to the exclusion of foreigners and non-resident Indians provided they have attained majority.

Entitlements:

It offers the following six types of policies:

1. Whole Life Assurance (Gram Suraksha)
2. Endowment Assurance (Gram Santosh)
3. Convertible Whole Life Assurance (Gram Suvidha)
4. Anticipated Endowment Assurance (Gram Sumangal)
5. 10 Year RPLI (Gram Priya)
6. Children Policy (Bal Jeevan Bima)

Source:

https://pli.indiapost.gov.in/CustomPortal/Documents/Rural%20Postal%20Life%20Insurance_Intro_Eligibility_Features.pdf

Name of the Scheme:

2. Gram Sumangal (Anticipated Endowment Assurance)

Brief details of the Scheme:

Gram Sumanagal Rural Postal Life Insurance Scheme is an endowment scheme which provides people living in rural areas to receive cash backs on a regular basis along with insurance cover. There are two types of plans under this scheme.

The Gram Sumangal Rural Postal Life Insurance Scheme, also referred to as the Anticipated Endowment Assurance is a money-back scheme. The policy is ideal for individuals who have periodic requirements of cash for their short-term financial liabilities. This scheme is targeted to provide insurance cover to the people belonging to rural areas. There are two types of plan under this scheme - 15 years term and 20 years term.

Eligibility:

Minimum entry age: 19 years

Maximum entry age: 45 years - 15 year term 40 years 20 year term

Employees of:

1. State Government
2. Reserve Bank of India
3. Central Government
4. Local Bodies
5. Defence Services
6. Public Sector Undertakings
7. Para Military Forces
8. Government-aided Educational institutions
9. All scheduled Commercial banks
10. Autonomous bodies
11. Financial institutions
12. Nationalized banks
13. Extra departmental agents in Department of Posts

Entitlements:

It is a Money Back Policy with maximum sum assured of ₹ 50 lacs, best suited to those who need periodical returns. Survival benefits are paid to the insurant periodically. Such payments will not be taken into consideration in the event of unexpected death of the insurant. In such cases, full sum assured with accrued bonus is payable to the assignee nominee of legal heir.

1. Policy term: 15 years and 20 years
2. Minimum age 19 years: maximum age at entry 40 years for 20 years' term policy & 45 years for 15 years' term policy
3. Survival benefits paid periodically as under: -
4. 15 years Policy: 20% each on completion of 6 years, 9 years & 12 years and 40% with accrued bonus on maturity.
5. 20 years Policy- 20% each on completion of 8 years, 12 years & 16 years and 40% with accrued bonus on maturity
6. Last declared bonus -₹47/- per 1000 sum assured per year

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pli.php>

Name of the Scheme:

3. Suraksha (Whole Life Assurance)

Brief details of the Scheme:

This is a scheme where the assured amount with accrued bonus is payable to the insured either on attaining the age of 80 years, or to his/her legal representatives or assignees on death of the insured, whichever occurs earlier, provided the policy is in force on the date of claim.

Eligibility:

Minimum & Maximum age at entry: 19-55 years

Entitlements:

1. Minimum Sum Assured 20,000; Maximum 50 lac
2. Loan facility after 4 years
3. Surrender after 3 years
4. Last declared Bonus-85/- per 1000 sum assured per year

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pli.php>

Name of the Scheme:

4. Santosh (Endowment Assurance)

Brief details of the Scheme:

Under this scheme the proponent is given an assurance to the extent of the sum assured and accrued bonus till he/she attains the pre- determined age of maturity i.e. 35, 40, 45,50,55,58 & 60 years of age.

Eligibility:

Minimum & maximum age at entry: 19-55 years

Entitlements:

In case of death of insurant, assignee, nominee or legal heir is paid full amount of sum assured with accrued bonus

1. Minimum sum assured 20,000; Maximum 50 lac
2. Loan facility after 3 years
3. Surrender after 3 years
4. Last declared Bonus ₹58/- per 1000 sum assured per year

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pfi.php>

Name of the Scheme:

5. Santosh (Endowment Assurance)

Brief details of the Scheme:

This is a Whole Life Assurance Policy with the added feature of an option to convert to Endowment Assurance Policy at the end of five years of taking policy.

Eligibility:

Minimum & maximum age at entry: 19-55 years

Entitlements:

1. Assurance to the extent of sum assured with accrued bonus till attainment of maturity age
2. In case of death, assignee, nominee or legal heir paid full amount of sum assured with accrued bonus
3. Minimum sum assured 20,000; Maximum 50 lac
4. Loan facility after 4 years
5. Surrender after 3 years
6. Last declared Bonus- ₹85/- per 1000 per year (for WLA policy if not converted to Endowment Assurance)

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pli.php>

Name of the Scheme:

6. Yugal Suraksha (Joint Life Assurance)

Brief details of the Scheme:

It is a Joint Life Endowment Assurance in which one of the spouses should be eligible for PLI policies.

Eligibility:

- Minimum age & Maximum age at entry of spouses: 21-45 years

Entitlements:

1. Life cover to both spouses to the extent of sum assured with accrued bonus.
2. Minimum sum assured 20,000; Maximum 50 lac
3. Maximum Age of the elder policy holder should not be more than 45 years & the couple should be between 21 years to 45 years.
4. Loan facility after 3 years
5. Loan after 3 years
6. Death benefits are paid to either of the survivors in the event of death of spouse or main policy holder
7. Last declared Bonus-₹ 58/- per 1000 sum assured per year

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pli.php>

Name of the Scheme:

7. Bal Jeevan Bima (Children Policy)

Brief details of the Scheme:

The scheme provides life insurance cover to children of policy holders.

Eligibility:

1. Maximum two children of policy holder (parent) are eligible
2. Children between 5- 20 years of age are eligible

Entitlements:

1. Maximum sum assured 3 lac or equal to the sum assured of the parent, whichever is less
2. Policy holder (parent) should not be over 45 years of age.
3. No premium to be paid on the Children Policy, on the death of policy holder (parent). Full sum assured and bonus accrued shall be paid on completion of term
4. Policy holder (parent) shall be responsible for payment of Children policy
5. Attract the rate of bonus applicable for Endowment policy (Santosh) i.e. last bonus rate is ₹ 58/- per 1000 sum assured per year.

Source:

<http://postallifeinsurance.gov.in/innerpage/insurance-plans-in-pli.php>

16. Ministry of Micro, Small and Medium Enterprises



Name of the Scheme:

1. **Rajiv Gandhi Udyami Mitra Yojana**

Brief details of the Scheme:

This scheme aims to:

1. Provide handholding assistance and support to the potential entrepreneurs who have completed or pursuing Entrepreneurship Development Training Programme (EDP)/ Skill Development Training Programme (SDP)/ Entrepreneurship cum Skill Development Training Programme (ESDP)/ Vocation Training Programmes (VT), through selected lead agencies.
2. Provide information, guidance, support and assistance to entrepreneurs and other existing entrepreneurs through 'Udyami Helpline.

Eligibility:

1. Existing national level Entrepreneurship Development Institutions (EDIs).
2. Micro, Small and Medium Enterprises Development Institutes (MSMEDIS)/ branch MSMEDIS.
3. Central/ State Government public sector enterprises that are involved in the promotion and development of MSEs.
4. Selected State level EDIs and Entrepreneurship Development Centres in the public and private sectors.
5. Khadi and Village Industries Commission (KVIC).
6. Special Purpose Vehicles (SPVs) that are established for cluster development involved in entrepreneurship development.
7. Capable associations of MSEs/ SSIS.
8. Other organisations/ training institutions/ NGOs etc. involved in entrepreneurship development/ skill development.

Entitlements:

Financial assistance to the selected lead agencies i.e. Udyami Mitras for rendering assistance and handholding support to the potential first generation entrepreneurs.

Whether PLHIV are included?

No

Source:

<https://www.india.gov.in/rajiv-gandhi-udyami-mitra-yojana>

17. Ministry of Coal



Name of the Scheme:

1. Inclusion of STI/HIV specific initiatives/projects under its health/medical care through welfare fund/CSR.

Facilitate schemes and entitlements for Social Protection to PLHIV through labour welfare associations.

Brief details of the Scheme:

It is aimed at reaching larger number of workforce engaged in coal mines and allied industries including migrant workers, truckers and surrounding communities with information on STI/HIV/AIDS, integration of HIV related services in existing health infrastructure as well as adoption of National Policy on HIV/AIDS and World of Work by coal PSUs.

Eligibility:

- Open to all staff, and
- Allied workers like:
 - Migrant labour,
 - Casual labour,
 - Truckers and
 - Surrounding communities.

Entitlements:

Information on STI/HIV/AIDS,

Integration of HIV related services in existing health infrastructure as well as and Adoption of National Policy on HIV/AIDS and World of Work by coal PSUs.

Action plans are developed for:

1. Coal India and their eight subsidiary units are mobilized.
2. Central Coalfield Limited,
3. Coal India Limited,
4. Singareni Collieries Company Limited,
5. South Eastern Coalfield Limited,
6. Neyveli Lignite Corporation Limited.

Whether PLHIV are included?

Yes

Source:

<https://coal.nic.in/>

<http://naco.gov.in/sites/default/files/Signed%20MoU%20Between%20Ministry%20of%20Coal%20and%20DAC.pdf>

18. Ministry of Tribal Affairs



Name of the Scheme:

1. **Development of Particularly Vulnerable Tribal Groups (PVTGs)** In addition to the above scheme, many other schemes are available for institutes and voluntary agencies. i.e.

Girls/Boys hostels for STs

Ashram Schools in Tribal Sub Plan areas Vocational training centres in tribal areas

Grant-in-Aid to State Tribal Development Cooperative Corporations and others

Village Grain Bank Scheme

Brief details of the Scheme:

The scheme aims at planning their socio-economic development in a comprehensive manner while retaining the culture and heritage of the community by adopting habitat development approach and intervening in all spheres of their social and economic life, so that a visible impact is made in improvement of the quality of life of PVTGs.

Eligibility:

- Particularly Vulnerable Tribal Groups (PVTGs)

Entitlements:

1. Livelihood
2. Employment opportunities and economic development of PVTGs through Agriculture, Horticulture, Animal Husbandry, Dairy, and Skilling/Vocational Training
3. Education, (Literacy, Drop-out, Residential schools in addition to SSA/RMSA)
4. Health, (Gap filling for effective health service delivery beyond NHM etc.)
5. Provision of safe drinking water (gap filling where line Ministries do not provide complete/universal coverage)
6. Land distribution, land development
7. Social security
8. Housing and Habitat
9. Connectivity (Road and Telecommunication)
10. Supply of Electricity (gap filling where line Ministries do not provide complete/universal coverage), Solar power, with provision of maintenance.

11. Irrigation (gap filling where line Ministries do not provide complete/universal coverage)
12. Urban Development
13. Sports including traditional and tribal games and sports
14. Culture
15. Any other innovative activity for the comprehensive socio-economic development of PVTGs

Whether PLHIV are included?

No

Source:

[https://tribal.nic.in/writereaddata/Schemes/4-5NGORevised Scheme.pdf](https://tribal.nic.in/writereaddata/Schemes/4-5NGORevised%20Scheme.pdf)

<https://www.india.gov.in/schemes-ministry-tribal-affairs#:~:text=Scheme%20of%20Grant%2DIn%2DAid,the%20Welfare%20of%20Scheduled%20Tribes&text=Get%20information%20about%20Scheme%20of,funded%20by%20the%20Central%20government.>

19. Ministry of Petroleum and Natural Gas



Name of the Scheme:

1. Pradhan Mantri Ujjwala Yojana (PMUY) Village Grain Bank Scheme

Brief details of the Scheme:

Providing LPG connections to BPL households will ensure universal coverage of cooking gas in the country. This measure will empower women and protect their health. It will reduce drudgery and the time spent on cooking. It will also provide employment for rural youth in the supply chain of cooking gas.

Eligibility:

- Woman above the age of 18 years.
- The women applicant should belong to BPL (Below Poverty Line)
- The women applicant should have a saving bank account in any nationalized bank across the country

Entitlements:

The connection charges would be borne by the Government, the OMCs would provide an option for the new consumer to opt for EMIs, if she so desires, to cover the cost of a cooking stove and first refill. The EMI amount may be recovered by the OMCs from the subsidy amount due to the consumer on each refill; In case the State Government or a voluntary organization or an individual wishes to contribute the cost of a stove and/or first refill, they would be free to do so in coordination with the OMCs. However, this would be under the overall umbrella of PMUY and no other Scheme name/ tagline would be allowed without express approval of the Ministry of Petroleum and Natural Gas (MoP&NG)

Only three States Haryana, Punjab and Andhra Pradesh - and the Union Territories of Delhi, Chandigarh, Daman & Diu, Dadar & Nagar Haveli, Andaman & Nicobar Island and Puducherry have become kerosene-free.

Source:

<http://petroleum.nic.in/>



National AIDS Control Organisation

India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

