Social Contracting in the HIV/AIDS Programme of India

Amaltas

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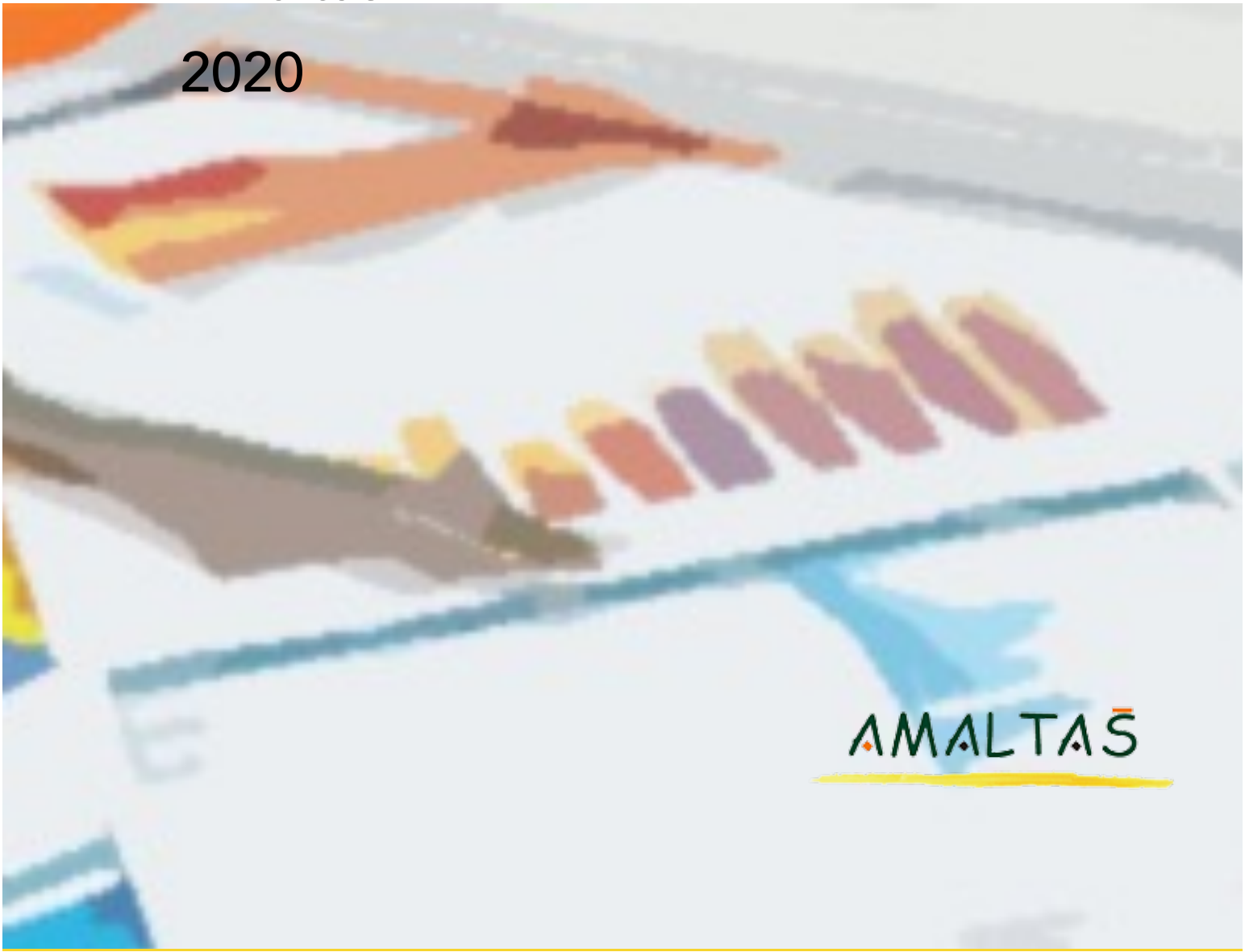

DISCLAIMER

The views expressed in this report are those of the team members. They do not represent those of UNAIDS or of any of the individuals and organizations referred to in the report.

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-Retroviral Therapy
AUSAID	Australian Agency for International Development
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CSO	Community Service Organisation
DFID	UK Department for International Development
DIC	Drop-In Centre
DMSC	Durbar Mahila Samanwaya Committee
EOI	Expression of Interest
ESRM	Experience Sharing and Review Meeting
FSW	Female Sex Worker
GTZ	German Technical Cooperation Agency
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IBBA	Integrated Biological and Behavioural Assessment
IBBS	Integrated Biological and Behavioural Surveillance
ICMR	Indian Council of Medical Research
ICTC	Integrated Counselling and Testing Centre
IDA	International Development Association
IDU	Person who Injects Drugs/Injecting Drug User
INR	Indian Rupee
JAT	Joint Appraisal Team
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Government Organisation
OST	Opioid Substitution Therapy
PEPFAR	President's Emergency Plan and Funding for AIDS Relief
PLHA	Person Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SACS	State AIDS Control Society
SDNS	Secondary Distribution of Needles & Syringes
STI	Sexually Transmitted Infections
TAC	Technical Advisory Committee
TG-H	Transgender/Hijra
TI	Targeted Intervention
TSU	Technical Support Unit
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USD	United States Dollar

EXECUTIVE SUMMARY

INTRODUCTION

The Human Immunodeficiency Virus (HIV) epidemic began in 1981 when the first cases were reported from North America. Although the world responded rapidly to the expanding epidemic, by 2019 it has already cost the lives of over 32 million persons [UNAIDS 2019]. The present epicentre of the epidemic lies in Sub-Saharan Africa.

India reported the first cases of HIV infection in the country in 1986. After an exponential growth curve, HIV infections reached peak levels in India in 2001-03 with 21.6 million cases. Both prevalence and death rates have fallen remarkably since then, to today's 2.1 million cases. Because of its large population base, India has the third highest number of cases in the world even with a very low prevalence. **A striking feature of the Indian epidemic is its concentration in high risk groups (HRG) practising unprotected sexual contact with multiple partners and injecting drug use.** This means that the rate of infection is much higher among injecting drug users (IDU: 6.3%); transgender persons/Hijra (TG-H: 3.1%); men-who-have-sex-with-men (MSM: 2.7%); and female sex workers (FSW: 1.6%) than in the general population.

India has mounted a definitive response to the epidemic, setting up the National AIDS Control Programme (NACP) run by the National AIDS Control Organisation in the Ministry of Health and Family Welfare. NACP is credited with significantly slowing the epidemic in India. Central to NACP's success is a cost-effective, community-driven targeted prevention model – Targeted Interventions or TI - to address the infection among groups in which it is most intense.

Partnerships with civil society organisations– both non-governmental organisations and community based organizations – have been at the heart of the prevention programme. By socially contracting these organisations, the programme instituted TIs that address the difficult issues of marginalisation, stigma, discrimination, police action and violence that the communities face. Their work complements and supplements government efforts and widens the reach of the programme. This community partnership has built greater transparency, governance, accountability and partnership between the government and civil society organisations.

The process of social contracting does not only include grant-making by government, but also legislative, policy and programmatic initiatives to ensure the successful initiation and completion of implementation. India has been conscious to ensure that the environment within which the social contracting (TI) programme is to take place enables a programme of work with civil society organisations that can respond to the evolving needs of the NACP.

RESPONDING TO A CONCENTRATED EPIDEMIC

Four phases of the NACP have been implemented. Between the discovery of the first cases and 1992, the early years saw the institution of the AIDS Task Force and Medium Term Plan [1990-1992]. The focus was on information and education campaigns, establishment of a surveillance system, and safe blood supply; but it was clear that an institutionalised response would be required. In 1992, the NACP was put in place. The first two phases of the NACP [NACP I & II] ran until 2007. During NACP I, expansion of the epidemic and its fall out in terms of stigma and discrimination by the community and medical establishment, made reaching HRGs difficult, but imperative. The seeds of the social contracting programme were laid by experimental programmes designed to expand service outreach to sex workers in Kolkata through the Durbar Mahila Samanwaya Committee collective.

By the time NACP II was designed, learning from the early pilots was folded into focused TIs with high risk populations. TIs used a peer-led model, enhancing participation of HRGs by drawing upon their experience for community level work. Because they were situated within the communities themselves, they took a partnership approach to affected populations. But at the time, peer-led organisations were few and the National AIDS Control Organisation had to make do with the credible non-governmental organisations that it was able to identify. As more information about prevalence of HIV in the MSM population came in, MSM civil society organisations helped set up new community based organisations and TIs for MSM. TIs for IDUs were also instituted. Over time, these TIs became NACP's most emblematic component.

A key period was that of NACP III [2007-2012], when the TI programme saw its greatest expansion and systematisation. Community mobilisation became the cornerstone of prevention efforts and social contracting became a vital part of the NACP. TIs were structured on principles of equality and inclusion to create an enabling environment in addition to providing prevention services. More and more services were planned through peer-led TIs run by community based organisations rather than non-governmental organisations. Specific guidelines were developed to address strengthening of community based organisations and building of new community based organisations from scratch. Contracts became more specific and streamlined.

NACP IV [2012-2020] continues to feature a strong revamped and revised TI strategy. The overarching principle is the 'differentiated approach'. HRGs are segmented on basis of risk and vulnerability; 'low-risk' HRG populations who are well aware of risky behaviours and taking suitable precautions are provided routine services, freeing up resources to focus on newer spots and hitherto unknown populations. Prevention services for HRGs and bridge populations have been scaled up nationwide. Transgender persons and Hijra previously included in MSM TIs have been allocated separate TIs.

Funds for prevention services through TIs have remained prioritised through the life of the NACP. Technical and funding partners helped to ensure that the programme was well resourced early on, with greater domestic allocations coming in as external funding has receded. There is a robust system for tracking of results. The social contracting TI programme has resulted in 1443 NGO/CBO-led TIs reaching over 776,000 FSW, 151,000 IDU, 265,000 MSM, and 41,000 TG-H in 2019. In turn, this has led to the lowest prevalence rates since the early 2000s; adult HIV

prevalence (15–49 years) is estimated to be 0.22%. HIV incidence per 1000 general population is only 0.07.

SOCIAL CONTRACTING IN PRACTICE

It has been over three decades since the epidemic began in India; the country has demonstrated a resolute focus on prevention. One fact has remained uppermost in the minds of India's planners and implementers: more than 99% of the country's population is HIV negative. It is their job to keep it that way.

The key to the success of India's HIV/AIDS programme is that it has been able to drive home the message of safe behaviour among most at risk population groups. The NACP has developed a clear programmatic response to the infection amongst HRGs and vulnerable populations; this is where social contracting has taken on its most well developed form. The programme has excellent operational guidelines for the TI programme, revised from time to time in light of new information. The guidelines provide direction to states and ensure consistency in the way that the programme is implemented. TIs have been put in place for core groups, i.e., FSW, MSM, IDU and TG-H, as well as for vulnerable communities namely, high risk migrants and long distance truckers. Each exhibit differentiated behaviours that require customised responses. Each group is provided a basic package of services under the NACP. The packages of services evolved under the TI programme have been instrumental in controlling the HIV epidemic in India.

The aim of a TI project is to effectively deliver project services to the HRG; increase the coverage of, and uptake of services by HRG; identify and effectively fill gaps in TI implementation; and set up efficient administrative and management systems to support these operations. A clear procurement process allows the selection of the right implementation partners. The NGO/CBO Selection Guidelines offer a systematic and transparent process for identification, field appraisal and selection of suitable organisations by State AIDS Control Society as well as expected deliverables – both administrative and financial.

The TI passes through three phases. Once a TI has been commissioned, the CSO must recruit staff and conduct training; undertake site assessment; and establish basic services. In phase II, peer educators are selected and trained and services are scaled up. This is followed by outreach planning to reach to 80-100% of the HRG population on a regular basis. In phase III, TIs must work to create an enabling environment. They supply services, condoms and raise awareness. Community mobilisation is directed to collective action, to influence safe behaviour norms and to address other structural barriers. Supportive supervision is an integral part of the programme, offering mentoring and handholding to TI managers. A monitoring system helps to capture programme results, both technical and administrative. Finally, evaluation is part of the TI's lifecycle, ensuring that results can be tested against ground realities.

National AIDS Control Organisation oversees the work of the NACP, formulating national policy, developing guidelines for the epidemic response, and ensuring that the state and districts are well resourced. National AIDS Control Organisation is assisted by the National Technical Support Unit, which supports the TI component of the programme. At the state level, State AIDS Control Societies translate the administrative role of NACO. State AIDS Control Societies are established

to manage and implement HIV activities in the respective states, driving more decentralised, strategized and focused activities. TI 'projects' are contracted, funded and monitored by these entities.

Technical Support Units have been established at state level to support State AIDS Control Societies to effectively manage civil society organisations. Technical Support Units oversee the quality and mentor and support TIs in conjunction with them. The remit of the Technical Support Units includes evidence based strategic planning and resource planning, capacity building, visits to civil society organisations that implement TIs, and activities related to the strengthening of TIs. The creation of Technical Support Unit is a revolutionary concept in public health wherein an outsourced wing provides technical inputs to the programme, so that health managers are free to concentrate on managerial activities. State Training and Resource Centres conduct capacity building activities for the TI programme in each state, training both civil society organisation staff as well as managerial cadres.

Social contracting has worked well because of the tremendous mutual trust between the government and the implementing civil society organisations. Involving key population representatives in policymaking, executive and technical committees that steer implementation design has not only built this mutual respect but also made interventions more robust. Community-led interventions leverage existing the organic bonding among community members, so individual members support their colleagues to access information and services. This leads to rapid and saturated coverage of the communities. Another key prerequisite of a social contract is trust and openness. Because of the unique threat posed by the HIV epidemic and the government offer to work with affected communities, the social contract becomes not merely a transaction, but a pact of confidence. NACO has made concerted efforts to gain the trust of civil society organisations by creating social space for FSW, MSM, TG-H and IDUs through both legal means or by raising acceptance for them.

Social contracting has offered an evolving value proposition to India's HIV/AIDS programme. Its value has corresponded with changes in the nature and dynamic of the epidemic. The reliance on large well established non-governmental organisation progressed into working with smaller community based organisations, collectives, networks, etc. The social contracting model also fostered the creation of an enabling environment. Civil society voice has become stronger over the years and has the space today, to influence policy and programme decisions. The programme has matured from a harm reduction to an empowerment and rights-based approach. **Mutual confidence between the government and community has been fostered by several progressive efforts of the government**. National AIDS Control Organisation's stance on consensual sex between consenting same sex couples, permission for opioid substitution therapy and support for the transgender persons bill have helped to build confidence. The HIV epidemic presented a collective threat to divided communities and gave them the reason to coalesce and mobilise. In the end, social contracting works because of the sense of community, binding person with person and community based organisation with the government.

LEARNING FROM THE HIV/AIDS PROGRAMME

It is no surprise that the NACP is well regarded. During its course it has worked closely with civil society organisations to deliver a decline in new infections of HIV and major reduction in the number of AIDS-related deaths. India adopted an intervention approach that targeted services to most at risk populations through civil society organisations that understood them. **Unique to the Indian programme, the TI component represents an investment that mobilises communities in order to help them, and focuses services on the population sub-groups that most require them.** Social contracting was instrumental in reaching populations that could not be reached by government programmes. Another value added by social contracting to the HIV response was in community mobilisation. This helped spotlight the need for a strengthened role for civil society in the planning and implementation of programmes and services and in particular, bringing to scale effective key population engagement programmes.

Despite all the other important issues that the NACP has had to grapple with, social contracting has remained its mainstay. All in all, the response to the epidemic has been a journey of learning. A major learning has been the need to have a strong evidence base. Evidence from research was used to reveal the diversity of the needs of the key populations, and pilots to fine-tune the response. **As HIV is concentrated among stigmatised and hidden populations, it was clear that the programme would have to empower marginalised key populations to give them the tools to change their risky behaviours.** The first step was to offer an identity to the key populations based on common experiences, concerns and needs. By claiming their identity, the key population began to see themselves as part of a community with greater power to bargain for their rights and access to services. The HIV/AIDS epidemic also had a more subtle effect; it made speaking of sex, gender and sexual relations no longer taboo. The HIV/AIDS epidemic challenged the social order and prevailing value systems in the country, garnering social acceptance for populations with different vulnerabilities and sexual orientation. The epidemic also wove change into the mind-set of people in the sector. Adopting a non-judgmental approach on the issues of morality transformed people's personal ethics and values and they became more accepting of differences.

As infection turned into epidemic, it became necessary to address the factors that were driving affected communities underground. The nodal Health ministry and National AIDS Control Organisation have been in discussions with key focal Ministries such as the Ministries of Home and Social Justice and Empowerment with respect to laws that pushed IDU, FSW and MSM away from services. Efforts by National AIDS Control Organisation coupled with strong activism by civil society organisations, resulted in change in many laws and policies. One such was the overturning of Section 377, an out-dated law criminalising consensual sex between same sex couples. A long-awaited legislation, the HIV and AIDS Prevention and Control Act that aims to end stigma and discrimination against persons living with HIV/AIDS in society was promulgated in 2017 and the Transgender Bill prohibiting discrimination against a transgender person was endorsed in 2019.

The NACP put in place strong administrative capacity at national and state levels in the shape of the National AIDS Control Organisation and State AIDS Control Societies. These are supported technically by Technical Support Units at both levels, specifically to enhance the

quality and capabilities of the TI programme. A senior level officer is placed in charge of the programme at both levels, ensuring that it runs smoothly and effectively. Technical capability was painstakingly created by gathering evidence, running pilots and building a robust monitoring and evaluation system. Detailed understanding of the disease was nurtured through sociological and anthropological studies leading to changes in the operations of the TI projects. Grassroots partners were urgently needed to ensure that there was enough coverage of HRGs. The programme focused on organisational development to ensure that reliable civil society organisations and networks were in place. The government took a flexible approach, supporting the handholding and mentoring by others with prior experience.

National guidelines for HIV testing have been revised to keep pace with global guidelines that recommend client-initiated voluntary counselling and testing, and provider-initiated testing and counselling for pregnant women, people infected with tuberculosis and sexually transmitted infections. National AIDS Control Organisation recognised the value of broader support for HIV prevention and encouraged linkages with care, support and treatment activities. Providing access to free Anti-Retroviral Therapy helped to enhance trust in the system. It encouraged more people to seek testing and connect with the national AIDS programme. Integrating care and support with prevention services has ensured that services reach not only the HRG populations who are HIV infected, but also their partners and/or spouses who are at elevated risk to the infection.

The UN system put a new agency United Nations Programme on HIV and AIDS (UNAIDS), into place to support countries' response to the situation. A new funding mechanism – the Global Fund against AIDS, TB and Malaria (GFATM) was created in 2002 as an international financing organisation that works in partnership with governments, civil society and people affected by HIV (in addition to malaria and tuberculosis). India has had the good fortune to have over 25 donors in support of the country's efforts. The World Bank has provided over USD 750 million over 20 years of HIV/AIDS programming. As the World Bank ceases its funding of the programme in India, domestic funds will be allocated to financing the critical component of TIs. President's Emergency Plan and Funding for AIDS Relief (PEPFAR), a technical partner since 2003 focuses on providing technical support along the prevention to care and treatment continuum under the Cluster Strategy.

A continued trust in non-governmental organisations and community based organisations as indispensable partners is helping to achieve programme goals. There are challenges of two types: first, enough trust has to be reposed in the communities to allow money to be transferred to them; and second, the financial management system must be flexible enough to ensure that they are never starved of funds. Continuing to find innovative ways to mobilise communities will be integral to prevention efforts. Programme timelines needs to allow for ground realities and be flexible insofar as the capacity building needs of individual community based organisations or networks are.

As social changes take place, communities shift and change their practice. Young and new entrants into sex work and drug use that are not within the TI coverage area must be identified. Strategies need to be designed to reach out and connect with younger and new HRG members. Training would be required for civil society organisations to develop the soft skills to reach 'hard

to reach' populations. Strategies to saturate coverage among key populations at physical spaces as well as reaching out to at-risk populations on virtual platforms are the need of the hour as the programme moves into the next phase of planning and implementation. Evidence generation through research and pilot projects are needed to build the evidence base to reach these populations.

In order to achieve the global HIV target of 2020 and 2030, to provide comprehensive prevention, testing, treatment package to vulnerable population TI Revamping Strategy has been developed. Through the TI Revamping Guidelines, newer activities are incorporated into the on-going TI programme in the context of the specific key populations, bridge populations and special groups.

The overarching principle for the revamped and revised TI strategy is the 'differentiated approach' to prevention such that each TI is not a 'one size fits all'. Operationalisation will segment the key population based on risk and vulnerability to help mitigate transmission of HIV so as to achieve more within the same inputs. The programme is focusing on reaching hidden HRGs beyond TI catchment areas, navigating to ensure linkages across HIV continuum of care, index testing, partner testing, network approach, Secondary Distribution of Needles & Syringes and satellite Opioid Substitution Therapy. Further, improving pay scales and prompt disbursal of funds to the non-governmental organisations and community based organisations must be explored to reduce attrition of staff and delays in programme implementation.

With well-led initiatives, political commitment, active engagement of civil society and additional funding, India can realize the vision for achieving the end of AIDS by 2030.

PREFACE by JS

ACKNOWLEDGEMENTS

Social contracting has been the mainstay of our prevention programme through involvement of community partners. A brief introduction about the TI programme. TO BE ADDED BY NACO/UNAIDS.

This documentation of Social Contracting in the HIV/AIDS Programme of India is an opportunity to showcase the work that the National AIDS Control Programme has been doing over the past three decades. At the National AIDS Control Organisation (NACO), we are delighted that the programme has achieved the success that it has. This is not least due to the tireless work of the organisation and its community partners. Today over 1440 interventions work to provide services, care and support to over 1.23 million HRG and over 10.26 million bridge populations through NGOs and CBOs.

NACO leadership and officials, programme managers TO BE ADDED BY NACO/UNAIDS.

NACO conveys its gratitude to the State administration specially Project Directors, State AIDS Control Societies, Tamil Nadu and Uttar Pradesh along with their teams for extending their support and cooperation to visits by the team and sharing their valuable perspectives and experience of handling the TI prevention programme in the respective States. We would also like to thank the experts who gave generously of their time, critical inputs to support the development of this document. The list of experts consulted is provided in Annexure I.

We wish to record our appreciation of the work by Amaltas Consulting Pvt Ltd and the authors, Dr. Suneeta Singh, Ms. Vaishali Sharma Mahendra, and Ms. Vrinda Gupta. They undertook review of over 180 documents, conducted over 35 interviews with experts around the country and made visits to two states to gather the background information for the report.

Finally, NACO would like to thank UNAIDS, in particular Dr. Bilali Camara and Ms. Nandini K Dhingra, for commissioning this important documentation of the work of the Targeted Intervention component of National AIDS Control Programme.

FOREWORD by SS

Chapter I
Introduction

In the last 40 years, the world has faced a gruelling challenge. A challenge posed by a sub-microscopic organism. A virus. The Human Immunodeficiency Virus or HIV as it is commonly known was first recognised through curious conditions triggered by the immunodeficiency it causes. In 1981, unexpected cases of *pneumocystis carinii* pneumonia and Kaposi's sarcoma among otherwise healthy young men led t its identification in North America. Within the first three years of the 1980s, it became clear that this dangerous virus could be transmitted through homo- or hetero-sexual relations, injecting drug use, unsafe blood transfusions or by infected mothers to their babies. By 1982, it was known that HIV causes AIDS or Acquired Immuno-Deficiency Syndrome which could ultimately lead to death by destroying the body's ability to fight off infection and disease. In the same year, the World Health Organisation held its first ever meeting to discuss the global AIDS situation and institute international surveillance.[1]

At its peak in 2005-06, the HIV epidemic killed over 2 million persons worldwide and almost 2.5 million persons acquired the infection in just one year. An approximate 38 million people across the world are living with HIV/AIDS. Presently, AIDS-related deaths per year are just over 1 million and approximately 1.7 million persons acquire new infections [UNAIDS 2019].[2] Although the number of persons infected with HIV has continued to grow, both new infections and AIDS-related deaths have unmistakably fallen. Through a process of understanding and learning, activism, advancement, reflection and momentum, the world community has been able to address the epidemic. Since it first began, the epidemic has cost the lives of over 32 million persons [UNAIDS 2019].

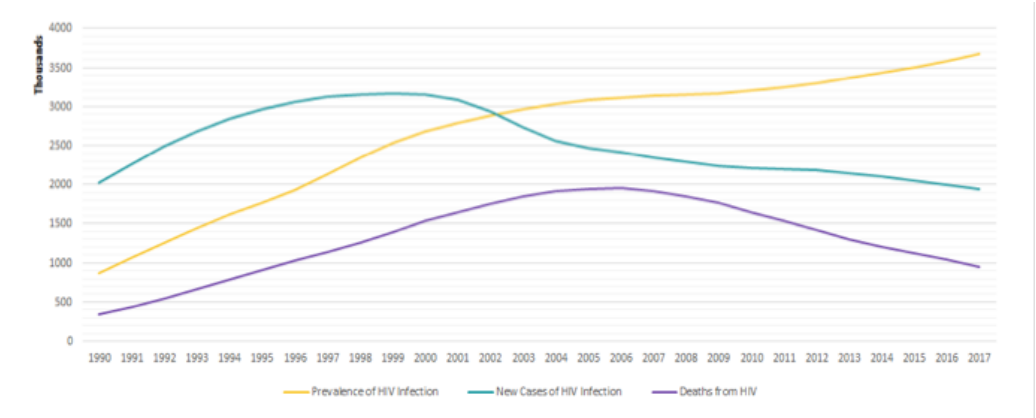

Figure 1: Prevalence, New Cases and Deaths from HIV&AIDS, World

The nucleus of the HIV epidemic today lies in Sub Saharan Africa. In most countries in the south of the region, prevalence rates are more than 100 per 100,000; while in South Africa and Mozambique, rates are over 200 per 100,000.[3] Despite its low HIV prevalence rate, with 1.9 million cases, India has the third largest cohort of persons living with HIV (PLHIV), after South Africa and Nigeria.

India's HIV Epidemic

In 1986, India's first cases of HIV infection were detected among sex workers in Chennai. After an exponential growth curve, HIV prevalence reached peak levels in 2001-03 with 21.6 million cases. Since its peak of 0.38% in 2001-03, adult HIV prevalence has shown a steady downward trend to 0.22% in 2017.[4] [5] Between 2003 and 2017, new infections have declined by 46% and AIDS-related deaths fell by 65%. The highest prevalence in the country is found in the north-eastern state of Mizoram. Five other states, Manipur and Nagaland (also in the north-east) and Andhra Pradesh, Karnataka and Telangana in the south of the country, have a prevalence that is more than double the national average.[6]

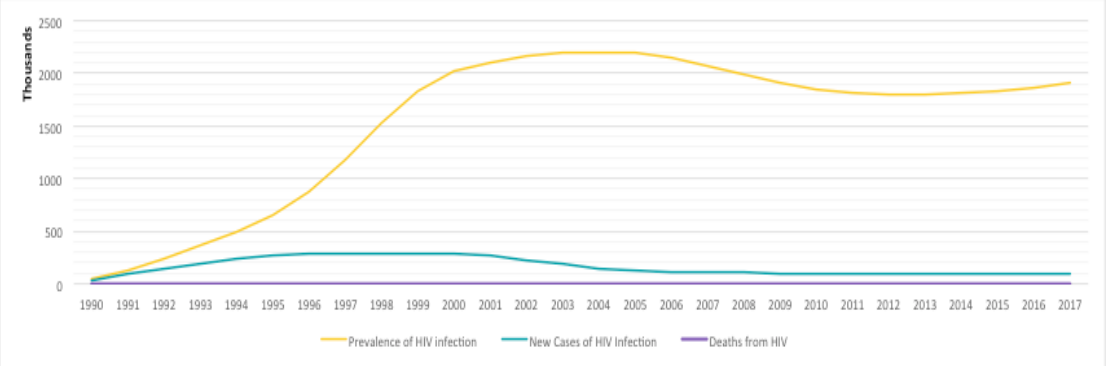

Figure 2: Prevalence, New Cases and Deaths from HIV&AIDS, India

The Indian epidemic is a 'concentrated epidemic' characterized by uneven distribution of the infection among groups that are most at risk of acquiring the infection. In the case of the Indian HIV epidemic, the concentration is among populations with high-risk behaviours i.e., unprotected sexual contact with multiple partners and injecting drug use. Much higher than average rates are found among injecting drug users (IDU: 6.3%); transgender persons[i]/Hijra[ii] (TG-H: 3.1%); men-who-have-sex-with-men (MSM: 2.7%); and female sex workers (FSW: 1.6%).[7]

Complicating this picture is the fact that these communities have been marginalised to the fringes of society. These high risk groups (HRG) have been hidden owing to discriminatory laws, ubiquitous stigma, discrimination and violence that they have faced. While sex work is not outlawed in India per se, soliciting for sex work is, and this has meant that the sex worker community and law enforcement agencies have been on the opposing spectrum at

[i] The term transgender or transgender persons when used in this document mostly refers to 'male-to-female transgender persons'.

[ii] Hijra: members of organized sect in South Asia who are born biological/anatomical males who reject their 'masculine' identity and identify either as a woman, or not-man, or in-between man and woman, or as neither man nor woman.

times. MSM were in fact outlawed; a stringent law - Section 377 of the Indian Penal Code - criminalised homosexual relations until recently. Injecting drug use is also outlawed, with users staying out of sight.

The national HIV/AIDS response has been credited for slowing down the epidemic in India. The National AIDS Control Organisation (NACO) was established within the Ministry of Health and Family Welfare (MOHFW) to carry out a comprehensive programme for the prevention and control of HIV/AIDS in India called the National AIDS Control Programme (NACP). Begun in 1992, the NACP has evolved into a major public health programme.[8]

Over its period, several development partners have contributed technical assistance and funds to the Government of India. These have included the UN system, notably UNAIDS, the specialised agency set up specifically to deal with the epidemic; bilateral agencies such as UK DFID, the Norwegian Agency for Development Cooperation, AusAID, US Government (through USAID, Centres for Disease Control and PEPFAR), CIDA and GTZ; multilateral institutions such as the United Nations, Global Fund and the World Bank; and philanthropies such as the Bill and Melinda Gates Foundation, Clinton Foundation and Elton John AIDS Foundation.

The HIV response has been a learning process, with the programme developing prevention strategies that have evolved in precision and coverage. The crucial reason for NACP's success has been the development of a cost-effective, community-driven prevention model to access some of the most difficult to reach communities at the centre of the epidemic. A key feature of the preventive effort has been its meticulous focus or targeting on key populations with high-risk behaviours among whom the infection has been raging.

A Community Partnership

In order to reach the marginalised groups, the programme worked closely with non-governmental organisations (NGOs) and community based organisations (CBOs) that comprised of or were empathetic to the key populations. This allowed a powerful effort to be made to reach out to those most affected. It is widely acknowledged that such (social) contracting of civil society organisations (CSOs) has provided a successful example of grassroots involvement in the health sector in India.[9]

Social contracting has been an important pillar of India's HIV&AIDS programme, led by the government in partnership with civil society organisations to reach and involve the community. In the NACP, this took the form of Targeted Interventions.

In the NACP, social contracting took the form of interventions targeted to assist those most at risk, formalised in the programme as Targeted Interventions (TI), as well as (in a smaller way) the contracting of People Living with HIV/AIDS (PLHA) networks to provide care and support. A crucial aspect of the epidemic response has been the manner in which CSOs, with the support of the government, were able to effectively address issues of stigma, discrimination and violence faced by those affected. The success with which these organisations played a critical role in HIV prevention, treatment, care and support services as well as rights advocacy and activism, have been driving factors for the programme's achievement.

The TI model adopted by India to contain the HIV/AIDS epidemic is of interest to other programmes within India as well as of other countries so that they can adapt and replicate positive changes in social contracting mechanisms for HIV programmes to fast track achievement of the 90-90-90 goals and end the AIDS epidemic by 2030. Therefore, it is important to understand what social contracting is, what value it adds to HIV programme, and how its modalities and lessons can be adapted to other settings and contexts.

What is social contracting? **Social contracting is an emerging concept** with an as yet evolving definition. The most commonly quoted definition that embodies its nature and purpose, states that, "social contracting is a process by which government resources are […] used to fund entities which are not part of government […], to provide health services which the government has a responsibility to provide, in order to assure the health of its citizenry".[10] Some interpret social contracting as the mechanism whereby a financing entity procures a defined set of services from a non-state provider. Others use it more broadly to refer to public resources channelled to CSOs to implement health or social sector related interventions. In the UNDP Guidance Note for the Analysis of NGO Social Contracting Mechanisms [2017], social contracting is defined with respect to both funding mechanism as well service provision for HIV, stating "… funding coming from the government at national and subnational levels to non-governmental organisations for the provision of HIV-related services to PLHIV and key and vulnerable populations."

In the health sector, the rationale for contracting out services by state to non-state organisations is rooted in the belief that the state is over-extended and cannot reach communities efficiently, alongside a presumption that management practices in the private sector are likely to be more effective.[11] Social contracting offers governments the option to extend and improve their health system. Since CSOs have a very different *locus standi* with respect to the community, they offer more personalized, flexible service and safeguard human rights, bringing a different perspective to the policy and planning process. They conduct experimental programmes that governments will not risk resources for, yet are often greatly needed. The work of CSOs complements and supplements government efforts and widens the reach of programmes that the government cannot or will not undertake. Furthermore, social contracting offers an opportunity to build greater transparency, governance, accountability and partnership between the government and CSOs. See Annexure 2 for other programmes in India that took a similar route.

> The HIV programme helped move the needle from approaching most at risk people as criminals, to one where they were provided support to raise their voice and engage with the administration and law enforcement authorities.

The Enabling Environment

The process of social contracting includes not only grant-making by government, but also legislative, policy and programmatic initiatives to ensure the successful initiation and completion of implementation. The government needs to be committed to making the legal,

policy and systems changes, including amendments to law or development of strategic plans to address the role NGOs will play in the response.

Social contracting requires that a country's legal and policy environment support the engagement of civil society and community organisations with the government. There should be no barriers to functioning of CSOs to work with vulnerable groups.[12] This needs preparation of byelaws, policies, strategies and guidelines that ensure that social contracting can take place.[13] It also requires that punitive laws, policies and practices against key populations (for example, criminalisation of same sex relations) be revised as they could prevent the transfer of external funds or allocation of domestic funding. In India, the political environment in India has become supportive to the HIV response partly due to the tireless, painstaking efforts of civil society, community activists and other development partners. The establishment of the National AIDS Council chaired by the Prime Minister formed an important avenue for greater legislative awareness of the problem, as well as support for policies required to counter the epidemic.[14] [15]

India's registration and regulatory mechanisms allow a range of CSOs to form as societies and trusts. An overwhelming number of CSOs in India are covered under the Societies Registration Act and Indian Trusts Act.[16] [17] Another important precondition to social contracting area is a supportive environment that facilitates CSO registration and their ability to receive and manage funds.[18] Registration, licensing and permissions should not become an obstacle for CSOs to provide services. These processes must be made as easy, inexpensive and affordable enough for NGOs, including grassroots groups such as collectives and CBO networks.

Procurement and contracting processes must be clear and transparent. Procurement must take into account the not-for-profit nature of NGOs and envision a system to ensure they are responsive in the public procurements market. Attention should be paid to who – government, CSOs or both – determines the thematic focus and modalities of such support. For instance, calls for proposals for government grants may have eligibility criteria that filter out smaller or larger CSOs.

Funding mechanisms must be in place to ensure that domestic and external finances are available for social contracting. State support to civil society is required through grants, subsidies, seed money etc. Other financial support such as special loans, tax exemptions, etc. could also be explored. CSOs in India enjoy privileges that make it attractive to donate to them, such as the Indian Income Tax Act which allows them to issue certificates for exemption from tax.[19] Legislation could also incentivise individuals and companies to donate to CSOs. The Foreign Contributions Regulation Act was very useful particularly in the early days of the epidemic, when bilateral and foreign grant making organisations provided funds to experiment with approaches to prevention, and care and support programmes.[20]

Ensuring quality control of publicly financed services is an important aspect of social contracting. The capacity of CSOs to implement programmes and of donors to identify, fund and monitor innovations are also essential for social contracting.[21] Commitment is needed to build these capacities in CSOs if it is already not in place.[22] Governments need to ready themselves to work with and through CSOs. In addition to financial accounting systems,

technical guidance must be prepared for implementation, supportive supervision systems put in place, and monitoring and evaluation established.

Providing supportive supervision and monitoring are critical in ensuring that contractual obligations are met; it also ensures that the quality of services provided is safeguarded and the community is benefitted. Financial reporting and monitoring is essential and regular audits must be required. On the flip side, are the consequences that CSOs may face in case of non-compliance with standards. The consequences need to be fair and proportionate to the seriousness of the violation. Care should be taken to ensure that quality control provisions do not place an excessive burden of reporting and inspection of the CSO partners.

Finally, it may be said that governments need to ensure that there are mechanisms in place to provide resources to civil society, including communities of key populations, and to forge working mechanisms for their meaningful engagement in effective and cost-efficient service delivery.[23] An enabling legal framework, clear policy articulations, conducive funding environment, and defined roles and capacity of partners to implement and monitor programmes are essential preconditions for social contracting to be put in place.

In the next chapter we discuss when social contracting in the form of TIs was first instituted in the HIV programme of India and how it evolved into the present-day format.

Chapter II
Responding to a Concentrated Epidemic

In the last two and a half decades, four phases of the NACP have been implemented, each with a duration of 5-7 years. The focus in each phase has been on improving coverage of comprehensive HIV prevention, care and treatment services nationwide albeit with varying degrees of scale and resourcing. Over the years, the programme has matured from a primary focus on raising awareness to behaviour change; from a common national response to a decentralized response; and from reliance on NGOs to a reliance on CBOs and networks of PLHA.[24] Social contracting of CSOs has played a critical role in the national response to the epidemic.

A distinctive feature of the Indian epidemic is how concentrated it has been among certain population groups with high risk behaviour such as injecting drug use and/ or unprotected sexual contact with multiple partners.[25] These groups referred to as HRG have borne the brunt of its impact as have their sexual contacts. The spread to the wider population has been limited, protected principally because of an unwavering focus on prevention services, treatment and care to the affected population groups. In short, to social contracting for TIs.

The Early Years

In the wake of the discovery of HIV, samples of female sex workers began to be tested. By May 1986, the first two cases of AIDS among Indians were reported from Chennai. This should have been a wakeup call, but in the early years HIV infection was not accorded public health priority in India. Ultimately, growing media reports of people living with HIV and their experiences of being denied treatment by hospitals, socially isolated, abandoned and in some cases driven to suicide, compelled attention and action by the government.[26] In response, an AIDS Task Force was set up which recommended widespread screening of populations for HIV infection.[27] By 1990, the country had developed a Medium Term Plan [MTP: 1990-1992] that facilitated targeted information and education campaigns, establishment of surveillance system, and safe blood supply.[28] However, it was becoming clear that an institutionalised response would be required.

The first fifteen years of the NACP were a time of great learning and experimentation. The first phase of the NACP [NACP I: 1992-1999] was implemented with the objective of slowing down the spread of HIV infection so as to reduce morbidity, mortality and impact of AIDS in the country. Unable to reach population groups most at risk, a nascent NACO focussed its efforts on bio-surveillance, promoting blood safety and awareness raising.[29] There was widespread discrimination against PLHIV within the medical establishment, in families and communities, and at places of work. Stigma moved up the agenda in the wake of legislative

debates around HIV risk.[30] Not much was known about the communities; they operated beyond the social pale as it were. These populations were also stigmatised; most of society was either unaware of their existence or contemptuous of their lives.

The fear of an exponential spread of HIV compelled the government to seek out most at risk groups. With a small grant from the World Health Organisation in 1992, the first programmatic piloting took place in two of the largest brothel settings in India - Kamathipura in Mumbai and Sonagachi in Kolkata. In Sonagachi, guided by an ideological framework of respect, reliance and recognition, the project transformed from an academic endeavour into a community owned project. The Durbar Mahila Samanwaya Committee (DMSC) collective set up in 1995 became the first community led HIV prevention intervention with sex workers. Regular condom use among sex workers in the pilot went up by 90% and HIV plateaued at less than 2%.[31] DMSC became a model for HIV prevention efforts. Similar experiences that mobilised MSM and IDUs from other CSO efforts were also emerging. These landmark efforts showed policymakers the benefits and success of involving CSOs in reaching out and working with the key populations.

By the time NACP phase II [NACP II: 1999-2007] began, an undisputed correlation had been established between unprotected, multi-partner sexual behaviour practiced by FSW, MSM, and truckers, and the transmission of the HIV infection. Consultations held to formulate NACP II made it apparent that the national programme would need a clear focus on prevention of new infections amongst the most at risk and vulnerable populations. Concurrently, there was emerging experience of how these invisibilised populations could be reached. This helped the NACP II to design focused (targeted) interventions with high risk populations. States were classified by HIV prevalence rate and vulnerability of the population in order to kindle urgency.

Interventions targeted to HRG populations were put in place to locate, reach and provide prevention services. These TIs used a peer-led model, drawing upon their experience of community level work to enhance people's participation. In partnership with CSOs, NACO provided HIV prevention services at places and during times when they were most needed. Because the TIs were situated within the communities themselves, they set a blame mind set aside, instead taking an active partnership approach to affected populations. Over time, TIs began to be seen as the bulwark against the unrelenting tide of HIV and these became NACP's most potent constituent. [32]

The capacity of civil society to implement Targeted Interventions was built over time. In the first instance, donors such as DFID and USAID worked with NGOs to develop models and pilot them.

Yet the programme struggled with implementation. Peer-led organisations were few and far between, and NACO had to steer towards NGOs to implement TIs. During the first half of NACP II, TIs focussed mostly on sex workers, women and children. There were only a few TIs directed to the MSM population. As more information about prevalence of HIV in the MSM population trickled in, MSM CSOs helped set up new organisations and TIs for MSM. TIs for IDUs were also instituted, but were mostly located in the north-eastern region of the country where IDU numbers were believed to be the highest. The response was built up one CSO at a time,

so that by the time that phase II was being closed, over 1200 CSOs had been engaged to provide TI services. Seen as the 'engines of the entire programme', these CSOs began to receive government funding.[33]

In 2002, a National AIDS Prevention and Control Policy was developed and adopted. Acknowledging the seriousness of the threat of the epidemic, a National Council on AIDS was constituted under the chairmanship of the Prime Minister of India, comprising of 31 Union Ministers, 7 Chief Ministers and leading civil society representatives to garner political commitment.[34] During NACP II, over 25 international organisations assisted the Government of India in its fight against HIV & AIDS.

Response from 2007-2012

As NACP II neared closure, a concerted effort was put in place to review the programme. Evidence was gathered from sentinel surveillance[iii], behavioural surveys, mapping, household surveys, operational research and programme monitoring and evaluations reports. Site visits, meetings with various civil society experts and agencies, extensive interactions with people at risk and people living with HIV, discussions with SACS staff were held. The consultative process involved experts from research and academic institutions, donor agencies and activists.[35] The formulation of the NACP III is globally acclaimed as an extraordinarily participative process.

Learning from previous phases of the NACP, pilots, models, research, mapping, surveillance were all used to build an evidence based project design. The experience of working with high risk groups came to fruition in NACP III.

The objective of NACP phase III [NACP III: 2007-2012] was to halt and reverse the epidemic. It placed the highest priority on scaling up prevention efforts among HRG and the general population.

Key activities of the TI strategy during this phase are highlighted in Table 1. They include behaviour change communication to increase demand for services; counselling and testing, risk reduction training and focus on partner referral for sexually transmitted infections (STI); promoting demand for condoms and ensuring their availability and easy access; and integrating prevention with care, support and treatment to facilitate access and use of these services by HRGs.[36] Special focus was given to IDU and MSM with greater flexibility and differentiation of TI solutions for each community's needs such as through provision of Opioid Substitution Therapy (OST)[iv] and lubricants respectively. TIs were scaled up dramatically in order to achieve high coverage of most at risk groups. To achieve this, partnership with CSOs for programme planning and implementation became the norm.

Based on lessons learned from DMSC and the Humsafar Trust, TIs were structured on principles of equality and inclusion so as to create an enabling environment. [37] Community mobilisation became the cornerstone of the prevention efforts and social contracting

[iii] Under this system, every year during a fixed period at a fixed facility, a fixed number of blood samples from the same category of people are taken in a consecutive sequence.

[iv] Opioid Substitution Therapy was included as a part of the Harm Reduction package in 2008.

became a vital part of the NACP. TIs undertook extensive community outreach, mobilisation and collectivisation, focus on human rights, action against violence and inequity, and activism. This led to greater and more meaningful engagement with the community. Moreover, broadening the notion of NGO involvement to work with subalterns was useful for NACO to build a constituency of support among these communities.[38] NACP III aimed to provide more and more of its services through peer-led TIs run by CBOs rather than NGOs. In fact, it offered a set of specific guidelines to address the strengthening of CBOs and building of new CBOs from scratch as well as from existing NGOs.[39] Contracts became more specific and streamlined, providing fixed contract value against given population reach and service.

Table 1: TI Package of Services in NACP III for HRG: FSW, MSM and IDU

Components	Principles	Services
Outreach and Communication	Peer led, NGO supported outreach and behaviour change communication.	a. Differentiated outreach based on risk and typology b. Interpersonal behaviour change communication
Service Delivery	Promotion of condoms, linkages to STI services and health services with a strong referral and follow-up system	a. Promotion/distribution of free condoms and other commodities e.g. lubricants for MSM, needles/syringes for IDU b. Provision of basic STI and health services including abscess management and OST for IDU and oral/anal STI services for MSM/TG-H. Partner referral for STI screening & management. c. Linkage to other health services e.g. for TB and voluntary counselling and testing centres d. Provision of safe spaces i.e., drop-in centres
Creating an Enabling Environment	Fostering equality and inclusion	a. Advocacy with key stakeholders/power structures b. Crisis management systems c. Legal/rights education
Community Mobilisation	Building community ownership of the TI's objectives	a. Collectivisation b. Creation of a space for community events c. Building capacity of FSW, MSM and IDU groups to assume ownership of the programme

NACP III became an excellent example of an evidence based design, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. In addition, it incorporated community-led and -owned strategies and reached out to high risk and vulnerable populations. The programme benefited from the role played by the civil society and PLHIV networks in community mobilisation, increasing access to services, addressing stigma and discrimination, and providing valuable insights into developing appropriate societal response.[40]

NACP Phase IV

NACP phase IV [NACP IV: 2012-2020] preparation began with the constitution of several working groups. Several think pieces were prepared to re-strategize the approach. NACP IV has the goal to consolidate gains made, accelerate the process of reversal, and further strengthen the response to the epidemic in India. Its objectives include: (i) reduce new

infections by 50% from the 2007 baseline of NACP III; and (ii) provide comprehensive care and support to all persons living with HIV/AIDS, and treatment services for all those who require it.[41]

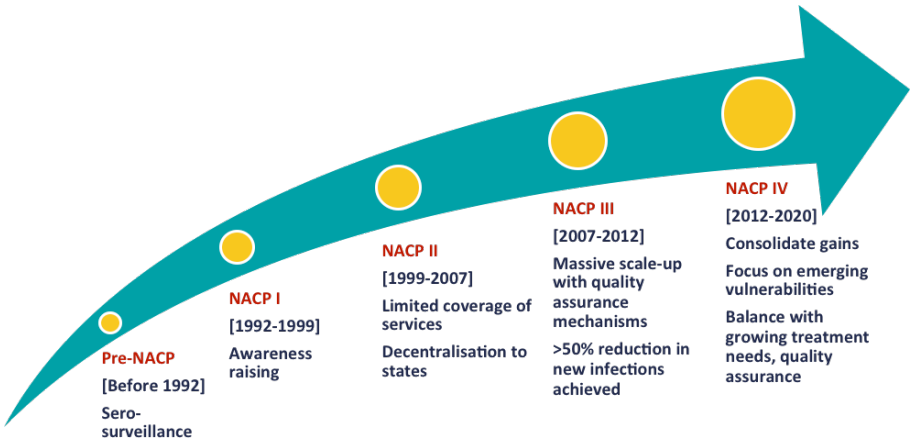

Figure 3: Evolution of the Response to HIV&AIDS, India

A revised and revamped strategy is foundational to the current phase of the programme. Evidence generated by TI programmes and HIV Sentinel Surveillance/Integrated Biological and Behavioural Surveillance (HSS/IBBS) highlighted the changing landscape of risk due to sexual and injecting behaviours among HRG, bridge populations and special groups. Such evidence gathering is a feature of the HIV/AIDS programme. After the first Mapping and HIV Estimation in 2008-09, the second carried out in 2017 provides updated and critical information on the status of the epidemic in the country. Data for the key indicators of adult HIV prevalence, annual new infections (HIV incidence), AIDS-related mortality and prevention of mother-to-child transmission (PMTCT) need is presented for the national level and across 35 states / Union Territories.[42] The exercise not only provides an estimate of the magnitude of the HIV epidemic, but also of the impact of prevention and treatment interventions.

> The epidemic changed in terms of numbers and the at-risk populations. Civil society organisations matured and grew; this made them more articulate and confident.

Furthermore, the Mid Term Review of NACP-IV and subsequent deliberations provided broad strategies to meet the emerging challenges of changing population dynamics, vulnerability and possible pathways that can contribute and lead to end HIV by 2030. As per the suggestions of various experts, Options Papers for all typologies of intervention were prepared. These option papers suggest how to re-prioritise districts based on evidence of risk and vulnerability as well as varying coverage and yield of programs; identify comprehensive designs for each of the key populations; review cost efficiency analysis; propose new models of outreach, including use of Information Technology and Social Media where needed; identify how to strengthen linkages within the continuum of HIV prevention; testing, treatment and care; and suggest methodologies to strengthen TI output on program performance. [43]

In response to these signals, the TI programme enhanced provision of the prevention and care continuum to HRG with a renewed focus on hard-to-reach populations. TG-H persons previously included in MSM TIs have been allocated separate and focused TIs. NACP IV has strengthened its TI strategy by incorporating new activities into its original four core elements, namely community outreach, service delivery, commodity distribution and community system strengthening. The overarching principle is the 'differentiated approach' towards prevention of HIV, segmenting HRG on the basis of risk and vulnerability.[44] 'Low-risk' HRGs who satisfy specified criteria I.e., associated with TI for more than five years; more than 45 years old; no reported case of STI in the last two years; remained HIV negative for over a period of five years, are provided routine services of HIV testing and condom supply. This frees up resources and allows outreach workers to focus on newer spots and hitherto unknown populations among FSW, MSM, IDU and TG-H.

Prevention services for HRGs and bridge populations have been scaled up nationwide. These provide a comprehensive package of prevention, support and linkage services to HRGs through drop-in centres (DIC) and an outreach-based service delivery model which includes free condoms (and lubricants), screening for and treatment of STI, behaviour change communication, an enabling environment with community involvement and participation, community mobilization and ownership building. In addition, TIs now support linkages to integrated counselling and testing centres (ICTC), and care and support services for HIV positive HRGs. For IDUs, the package includes free distribution of sterile needles and syringes, abscess prevention and management, OST and linkages to detoxification and/or rehabilitation services.[45]

During NACP IV, the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Act, 2014 was passed by the Indian Parliament and notified in April 2017. This Act safeguards the rights of PLHIV and those affected by HIV, addresses stigma and discrimination in all settings, and emphasises the need for an enabling environment. NACO is collaborating with various key Ministries of Government of India with the objective of a multi-pronged, multi-sectoral response to ensure better use of resources for risk reduction and impact mitigation.

Tracking Results

The consistent collection and use of routine monitoring data through a computerised system forms the foundation of NACP's strategic information system. But core indicators also rely on other information: annual quality assessments, bio-behavioural surveillance, research, and other special studies to measure achievements at the outcome and impact level. Latest reports show encouraging progress towards the national goals of curbing the epidemic and preventing new infections.

One achievement has been an increased coverage of key populations by preventive services through TIs. By March 2019, 1443 NGO/CBO-led TIs reached more than 775,000 FSW, 150,000 IDU, 270,000 MSM, and 41,000 TG-H. See Table 2. Implementation of TIs with

intensive coverage of HRGs has paid dividends leading to a decline in HIV prevalence in key populations.[46]

Table 2: TIs for HRGs and Bridge Population

Population Type	Mapping Estimate (2016-17)	April – September 2017		Until March 2019	
		Number of TIs	Population covered	Number of TIs	Population covered
Core HRGs					
FSW	86,800	389	6,00,000	346	776,237
IDU	35,700	205	1,14,000	193	151,945
MSM	7000	115	2,03,000	108	265,740
TG-H	177,000	32	30,000	36	41,176
Bridge Population					
Migrants (Destination)	7,200,000	212	25,21,000	200	7,660,619
Truckers	2,000,000	76	9,74,000	64	2,603,528
Core Composite[v]	438	496			
TOTAL		1467		1443	

Source: Note on Options Paper 2018-19 and NACO Annual Report 2018-19

NACO guidelines require HRGs to visit STI clinics every quarter for regular medical check-ups and treatment of STIs. All core HRGs are to be tested for HIV once every six months. The detection of positive cases amongst HRGs has been low ranging from 0.1% to 0.6% except among IDUs (1.12%).[47] Programme data reveals that HRGs who have been associated with TIs for more than five years have been testing regularly and are taking consistent efforts to remain negative across the majority of the states. This underscores the need to ensure robustness of data as it can drive the response and support for programme efforts.

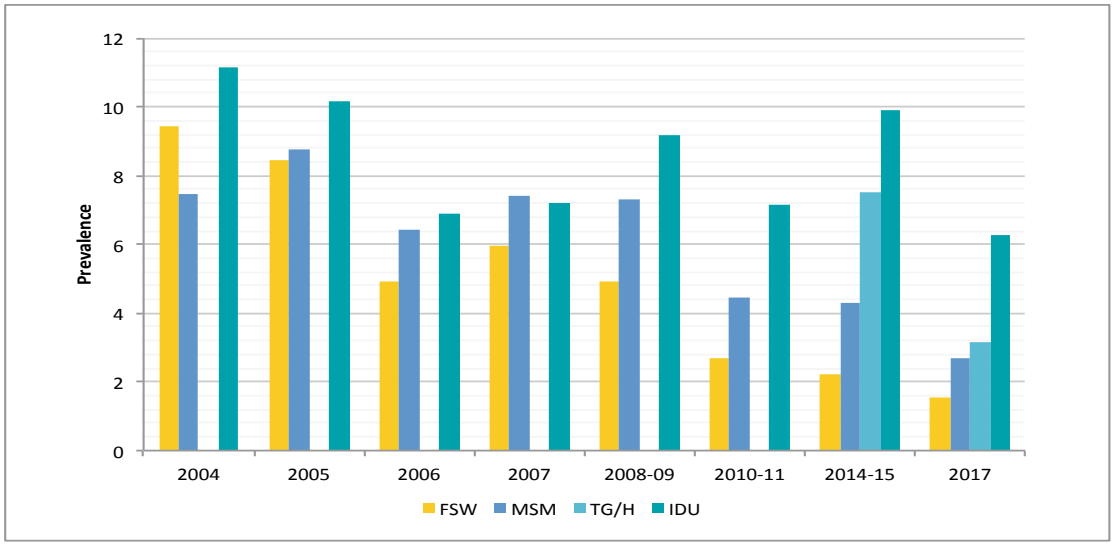

Figure 4: Decline in HIV Prevalence in Key Populations, India

[v] Core composite TIs cover multiple HRGs and are employed in areas where any one HRG population is not substantive enough in numbers to warrant a standalone intervention.

In summary, it was not feasible to start working with communities that are outcast and stigmatised straight away. Effort is needed to understand the nature of the problem and only then work on solutions. The HIV/AIDS programme started first with needs assessment, studies and awareness generation activities and then moved on to service provision, empowerment and collectivisation activities. The seeds of social contracting were sown in NACP II as the evolution of TIs took place. Nevertheless, it was only in NACP III that social contracting became NACP's most emblematic component.

Chapter III
Social Contracting in Practice

The HIV/AIDS epidemic is the story of the explosive spread of a deadly virus affecting mostly those living on the periphery of society. As Stemple (2008) notes in her fascinating article exploring the intersection of HIV with human rights, "Unlike the stories told of plagues past, in which scientific ignorance about the spread of disease seems more unfortunate than unjust, the story of AIDS will surely be a story about rights. The story of AIDS is about haves and have nots, and about discrimination, denial and indifference".[48]

India has been one of the earliest adopters of the principles that guide the just and unprejudiced response to the epidemic. Signatory to the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child - the three main international covenants that have bearing on the epidemic - India has responded with responsibility to her duties as a nation. NACP is committed to reaching the global Fast Track Strategy of 90-90-90, an ambitious target to end the AIDS epidemic.[vi] The guiding principles for NACP IV are a continued emphasis on the Three Ones.[vii]

India has lived with the HIV/AIDS epidemic for over three decades since the identification of the first case in the country. She has shown remarkable tenacity in the face of the epidemic; this has required a resolute focus on prevention. Even at the height of the epidemic, one fact has remained uppermost in the minds of India's planners and implementers: more than 99% of the country's population is HIV negative. It must be kept that way.

Package of Services

Increasing safe behaviour among most at risk population groups has been the key to reversal of the HIV epidemic. The NACP has developed a clear programmatic response to the infection amongst HRGs and vulnerable populations; this is where social contracting has taken on its most well developed form. TIs have been put in place for core groups, namely FSW, MSM, IDU and TG-H. In addition, the programme also focuses on vulnerable communities namely, high risk migrants and long distance truckers that act as 'bridges' between most at risk populations and the general population.[49]

[vi] The Fast Track Strategy is an international pledge that enjoins countries to ensure that by 2020, that 90% of PLHIV will know their status; that 90% will have been put on ART; and that 90% will show viral suppression and that by 2035, 95% of PLHIV will know their status; that 95% will have been put on ART; and that 95% will show viral suppression.

[vii] The Three Ones viz., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority, and one Agreed National M&E (Monitoring & Evaluation) System.

Over the years, the programme has developed excellent operational guidelines for the TI programme to aid in effective outreach and service provision.[50] These guidelines are revised from time to time in keeping with new information. They provide advice and direction to states and ensure that there is a basic consistency in the way that the programme is implemented across the country. The guidelines detail the key population, their typology and associated risk, and activities to be implemented. See Table 3 for a listing of useful documents:

Table 3: Useful documents developed by the NACP

#	Title	Hotlink to document	Date of publication
1	Revamped And Revised Elements Of Targeted Intervention	Download (1.83 MB)	12/06/2019
2	Targeted Intervention Revamped Strategies – National Training Of Trainers	Download (2.4 MB)	10/23/2019
3	Guidance Document On TB-HIV Linkages For Targeted Intervention And Link Worker Scheme	Download (42.5 MB)	10/22/2019
4	HIV And TB Intervention In Prisons And Other Closed Settings	Download (4.41 MB)	03/27/2019
5	Clinical Practice Guideline Management	Download (4.48 MB)	03/12/2019
6	Report - National Consultation On HIV Intervention In Prisons And Other Closed Settings	Download (4.04 MB)	03/12/2019
7	Prevention Report	Download (3.04 MB)	03/12/2019
8	Brief Write Up On The Publication - Prisons	Download (156.99 KB)	07/06/2018
9	Harm Reduction Report	Download (737.36 KB)	07/05/2018
10	Operational Guideline For MSM	Download (9.03 MB)	05/10/2016
11	Operational Guideline For TG	Download (3.58 MB)	05/10/2016
12	Clinical Guidelines On Opioid Substitution Therapy	Download (1.19 MB)	03/23/2015
13	Link Worker Scheme Operational Guidelines-2015	Download (3.03 MB)	03/11/2015
14	Policy, Strategy And Operational Plan HIV Intervention For Migrants	Download (5.51 MB)	02/24/2015
15	Operational Guidelines For Employer Led Model	Download (4.58 MB)	02/24/2015
16	Revised TI Costing Guidelines (2014) And TOR Of TI Staff	Download (1.06MB); Download (233.94 KB); Download (185.6 KB)	08/21/2014
17	Health Camp Guideline	Download (771.15 KB)	09/13/2012

Female Sex Workers are a core HRG, at risk because they have multiple, concurrent sexual partners. For the purposes of the programme, an FSW is identified as an adult woman who engages in consensual sex for money or payment in kind, as her principal means of livelihood. The higher risk of FSWs is reflected in a substantially higher prevalence of HIV among them than the general population. FSWs are categorised into six main typologies, based on where they work and more specifically, on where they recruit or solicit clients. They include brothel based, street based, lodge based, *dhaba*-based[viii], home based/secret sex workers, and highway based sex workers. Certain typologies have higher client volumes than home-based sex workers and require special focus.[51] [52] New entrants to sex work also warrant special focus.

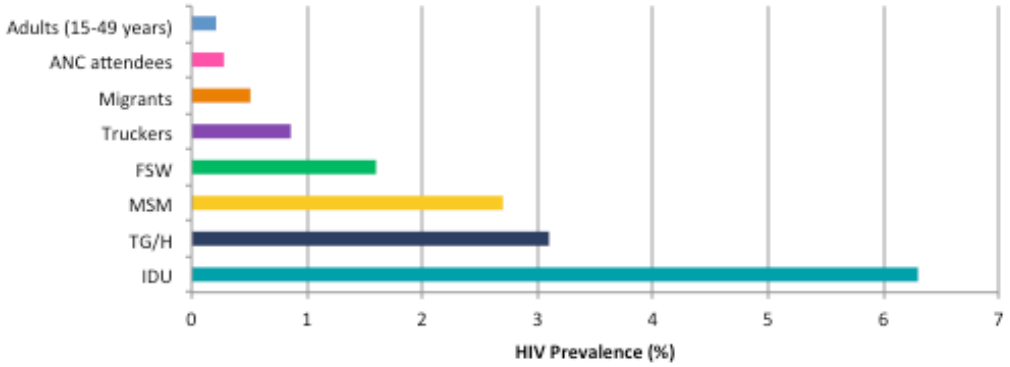

Figure 5: HIV Prevalence among General Population, Key Populations and Vulnerable Populations

Men who have Sex with other Men is the term used to describe men who have sex with men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not. Coined by public health experts for the purpose of HIV and STI prevention, this epidemiological term focuses exclusively on sexual practice. A man may have sex with other men but still consider himself heterosexual or may not have any particular sexual identity at all. MSM sub-populations that have high rates of partner change as well as a high number of concurrent sexual partners are at greatest risk. Those that engage often in anal sex are also at particular risk since HIV is more transmissible through anal sex than by other sexual practices.[53] For the purposes of TIs, only those high risk MSM are included who are self-identified anal receptors with multiple sexual partners. These groups are *kothis*[ix] and *double deckers*[x].[54]

The package of services evolved under Targeted Interventions has been instrumental in controlling the HIV epidemic in India.

Transgender persons and Hijra Exclusive TG-H interventions were started under NACP IV based on a high HIV prevalence rate among TG-H (8.8%) and different and specific HIV prevention and care needs. Transgender persons usually live or prefer to live in a gender role

[viii] Dhabas are roadside resting places for truckers and other long-distance motorists or road-side country motels.
[ix] Identified homosexual males who are feminine and involved mainly, though often not exclusively, in receptive anal/oral sex with men. Some proportion of *Kothis* have bisexual behaviour and many may marry a woman. The *Kothi* identity is shared by both feminine homosexual men and *hijra* i.e. male-to-female transgender/transsexuals.
[x] MSM who both insert and receive during penetrative sexual encounters (anal or oral sex) with other men.

different to the one assigned to them at birth. It is an umbrella term which includes transsexuals, cross-dressers, intersex persons, and other gender-variant persons. Transgender people may or may not have undergone sex reassignment surgery or be on hormonal therapy for gender transition.[55] *Hijra* belong to a distinct socio-religious and cultural group, a '*third gender*' apart from male and female. They cross-dress in feminine attire and are organised in India, under seven main *gharanas* (clans). The Hijra may be (castrated, *nirvan*), non-emasculated (not castrated, *akva/akka)* and inter-sexed persons (hermaphrodites).

Injecting Drug Users do not inject at all times during the span of their addiction. They may inject, fall back into oral or inhalation (non-injecting) drug use or abstinence, and then return to injecting.[56] For the purposes of programming, IDUs are classified as: (i) *Current injectors* who have used any drugs through injecting routes in the last three months; and (ii) *Shadow users* who have in the last six months, switched to oral or inhalation drugs when injecting drugs e.g. opioids, are not available. Conversely, when oral or inhalation drugs are not available, some users temporarily shift to injectable.[57]

Migrants are single (could be married or unmarried men or women who move alone without family) men and women in the age group of 15-49 years who move between source and destination within the country once or more in a year. Migrant TIs are destination interventions for in-migrants and focus on high risk migrant men and women who are part of high risk sexual networks, either as clients of FSW and high risk MSM, or as sex workers themselves.[58]

Truckers includes long distance truck drivers and their helpers who spend months at a stretch on the highways and are away from their family members for extended periods of time. They may have multiple sexual partners, including FSWs on the highways, at places where they stop for rest or food, or other fixed partners en rout*e*. They have a higher prevalence of STIs. Some truckers also have sex with male sexual partners.[59]

New activities have been incorporated under the revised and revamped package of TI services for key populations (see Table 4):

Table 4: Activities for key populations under the Revised and Revamped TI Package

Components	Sub-components	Purpose	Key Population Typology				
			FSW	MSM	TG-H	IDU	IDU Partners
Population Mapping and Size Estimate		To estimate HRG population size	✓	✓	✓	✓	
Community Outreach	Strengthen Outreach Activities	To increase coverage and reach out to HRGs sexual partners/networks of	✓	✓	✓	✓	
Service Delivery	Differentiated Prevention	To optimise resources and provide client centred services	✓	✓	✓	✓	✓
	Navigation	To improve linkages and adherence to ART	✓	✓	✓	✓	
	Index Testing	To test spouses /partners of PLHIV HRG after ART initiation	✓	✓	✓	✓	✓
	Community Based Screening	To provide counselling and testing to hard-to-reach HRGs	✓	✓	✓	✓	✓
Commodity Distribution	Secondary Distribution of Needles & Syringes (SDNS)	To improve access to Needle/Syringe exchange				✓	✓
	Satellite OST Centre	To improve access and adherence to OST				✓	✓
	Community Based ART Dispensing	To improve access and adherence to ART	✓	✓	✓	✓	
Community System Strengthening	Community Score Card	To seek community feedback to improve TI	✓	✓	✓	✓	

The TI Lifecycle

The aim of a TI project is to effectively deliver project services to the HRG; increase the coverage of, and uptake of services by HRG; identify and effectively fill gaps in TI implementation; and set up efficient administrative and management systems to support these operations.

The Procurement Process The key to an effective and efficient programme is the selection of the right implementation partners. In the case of NACP, the success of the TI component depends on the NGO, CBO and network partners that the programme chooses to work with.

The NGO/CBO Selection Guidelines offer a systematic and transparent process for identification, field appraisal and selection of suitable organisations by SACS as well as expected deliverables – both administrative and financial.

The first step in selection is an open call by SACS for Expressions of Interest (EOI) from NGOs, CBOs and networks in regional and local newspapers. A Technical Advisory Committee (TAC) screens applications and based on its preliminary review, transparently posts the details of applications received and their status on the SACS website. A Joint Appraisal Team (JAT) constituted by the Project Director SACS reviews short-listed organisations using the detailed guidelines available. The Team submits their report along with the Institutional Appraisal Score Sheet; Institutional Appraisal Observation Notes; and Field Appraisal Format.

Before a TI project can be instated, mapping of the HRG population is required. Short-listed applications are graded and if successful, requested by the Project Director SACS to conduct a mapping and needs assessment of the area.[60] The SACS conducts a Proposal Development Workshop for mapping and needs assessment for all successful organisations. SACS releases a small grant of INR 100,000 to conduct the assessment. This involves a review of secondary data; 'broad mapping' to estimate size; identify HRG typology and locations of risk; and a site assessment to derive insights into factors that make HRGs particularly vulnerable to HIV and to initiate interventions.

Over a period of eight weeks, organisations validate and map the size and location/sites of the core groups (FSW, MSM, TG-H, and IDU) and bridge populations (Truckers and short stay Migrants) in their assigned project area. Mapping is focused on most at risk subcategories, for example, *kothi* among the MSM rather than all MSM. Since mapping involves getting people to divulge sensitive information about their sexual behaviours, partners, locations, networks, etc., it is implemented through NGOs/ CBOs/ networks that are already implementing TIs. It is important to recruit representatives from all subcategories of HRGs that are available at a site onto the mapping teams, as they are most likely to know where to locate others in their community.

Once the mapping of HRGs by category is completed, analysis helps to define the scope and scale of needed TI coverage. Evidence shows that for interventions among HRGs to be cost-effective and impact efficient, each TI unit should aim to provide services to 800 to 1500 HRG members (150-350 for IDUs, and in select cases, up to 1000 where there are concentrations of IDUs). Based on the mapping and needs assessment report, the SACS decides on the number of interventions that the district needs. No organisation is supported for more than three TI projects. A contract of two years is awarded to NGOs to implement the TI in a selected geography with a specific key population target.[61] An Award of Grant letter consisting of the Agreement between the SACS and the CSO and a Performance Bond is issued.

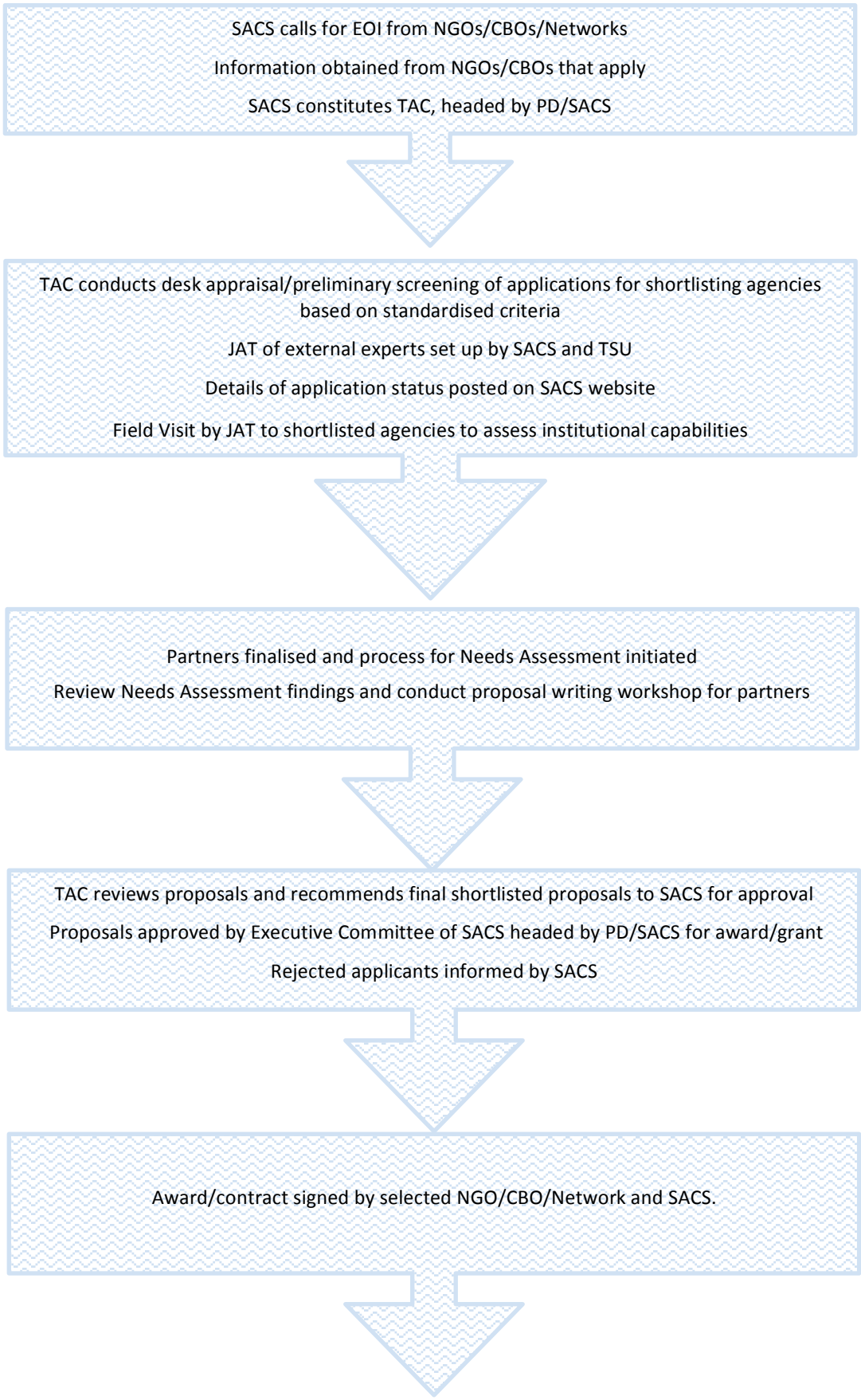

Figure 6: Flow Chart of Procurement of NGO/CBO/ Networks to run TIs

The TI passes through three phases:

Phase I: Once a TI has been commissioned, the NGO/CBO must set up the infrastructure for the project, recruit staff and conduct training; undertake site assessment; and establish basic services. Basic services that can be established quickly are referral systems for treatment of STIs, availability of free condoms and setting up of a DIC, also known as a safe space. 'Safe space' is a critical concept in the early phase of service delivery, especially for street-based populations. Public sites such as streets, parks, etc. do not allow much time to the outreach workers and peers for making meaningful contact with the key population. At DICs, FSW/ MSM/ TG-Hs can interact with each other, rest, seek advice, share information, approach someone in case of a crisis, or pick up condoms. Counselling and/or STI services can be provided at the DIC through counsellor and/or doctor visits on certain days/times. Referral to satellite services such as de-addiction, crisis response, social welfare schemes and services can also be provided through the DIC. Ideally, the DIC should be located close to the sex work sites or hotspots. The choice of the centre location will be dictated by availability and the preference of the community.[62]

Phase II: Peer educators are selected and trained and services are scaled up. This is followed by outreach planning to enable outreach to 80-100% of the HRG population on a regular basis in order to have maximum coverage and impact on HIV prevention.

To implement and operationalize the TIs and assure the quality of their services, the capacities of the organisations that will run the TIs needs to be strengthened. These include SACS, TSU, District AIDS Prevention Control Units as well as NGOs, CBOs and PLHIV networks.[63] General sensitization training programmes are focused to create awareness about HIV/AIDS as well as services and facilities that are available. Component specific training programmes focus on implementation of the programme. Programme officers receive managerial capacity building, whereas service providers receive technical capacity building. Training is administered as orientation, in-service and refresher sessions.

Spin offs from social contracting in India have been remarkable. For example, large community outreach, mobilisation of communities, rights based approach; rights based approach, activism and even action against partner violence.

Phase III: Providing services, supplying condoms and raising awareness may not in themselves result in sustained behaviour change. TIs must address barriers to change and work to create an enabling environment that ensures the right conditions for change. Community mobilisation in an HIV/AIDS programme context is directed to collective action, influence norms within the community for safe sexual behaviour and address other structural barriers. The contracted CSO is responsible to see that both goals of the TI programme, service oriented and empowerment oriented, are met.

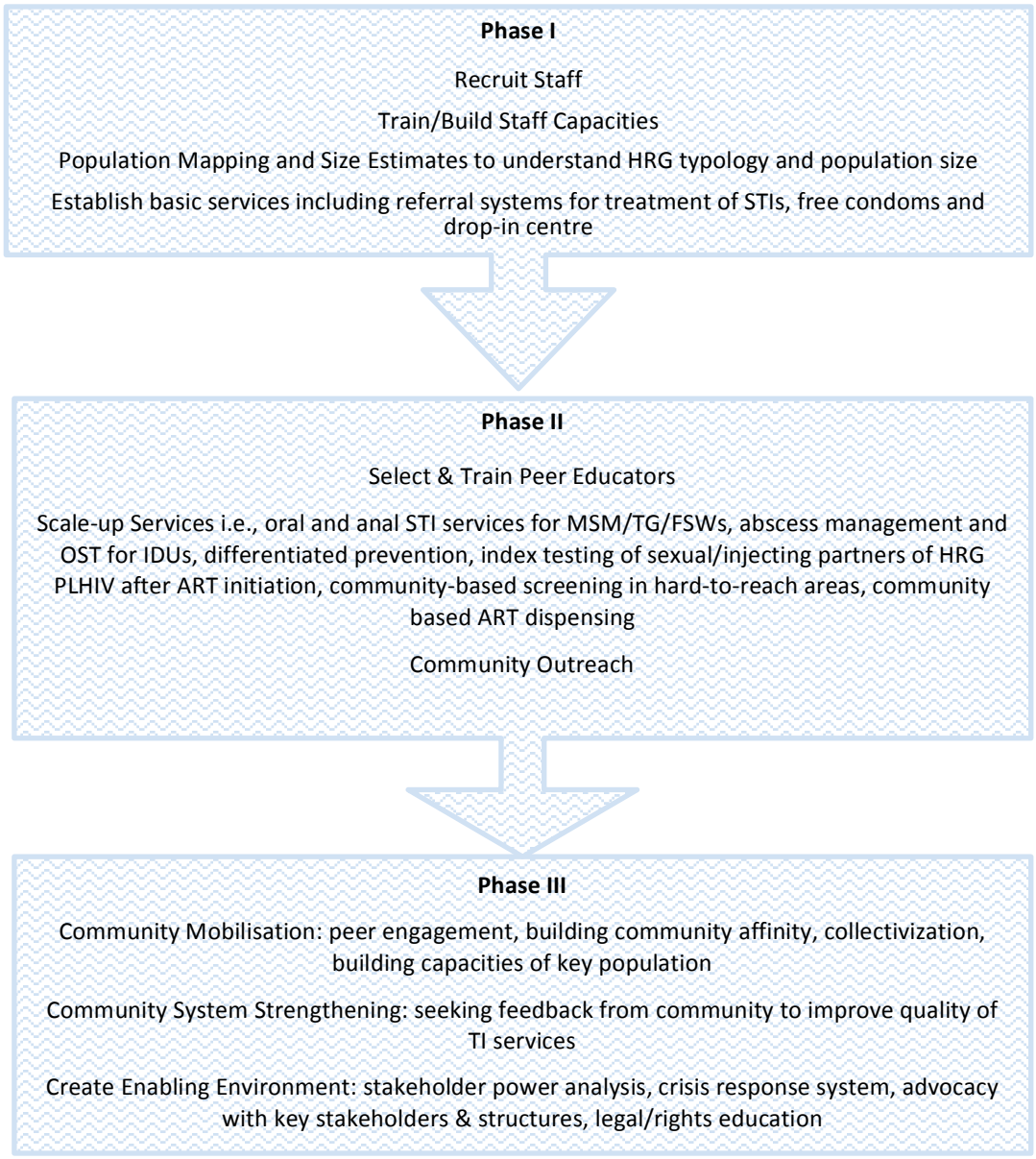

Figure 7: Flow Chart of steps in setting up a Targeted Intervention

Supportive Supervision Supervision begins with an induction programme for CSO partners by TSU and SACS within two months from the award of grant. A common understanding is developed about the proposal, TI strategies, reporting obligations to SACS including reporting formats, registers and computerised management information systems; and financial guidelines. CSOs are visited for mentoring and handholding support by programme officers and officials. Participatory site visits are also carried out once every six months by consultants who not only review records and registers, but also interact with the peer educators, target group, secondary community and service providers. NACO and national TSU officials also conduct field visits from time to time.

Experience Sharing and Review Meetings (ESRM) are held for each thematic intervention twice a year. At these meeting, field experiences and lessons learned are shared to

improvise strategies for identified gaps. Cluster Level Meetings in a particular geographical region are held quarterly to facilitate better coordination among partners. The aim of the Cluster Level Meetings is to share resources and to avoid duplication of efforts.

Table 5: Supervision, Monitoring and Evaluation activities

Type of Activity	Activities	Frequency	Responsible
Supportive Supervision	1. Participatory site visits	Once in 6 months	External consultants
	2. Experience Sharing and Review Meetings (ESRM)	Once in 6 months	TSU
	3. Cluster Level Meetings	Quarterly	CSO presenting to SACS/TSU/ External Consultant SACS/ TSU
Monitoring	1. Monthly Progress Report	Monthly	CSO via CMIS
	2. Feedback Analysis to CSO	Quarterly	SACS/TSU
	3. Program Management Committee meeting	Regular	SACS
Evaluation	1. Mid-term participatory evaluation	Mid-way of project cycle	External Evaluators/Agency
	2. Program Evaluation	Once every two years	External Evaluators/Agency
Surveillance	1. HIV Sentinel Surveillance (HSS)	Intermittent	NACO/SACS
	2. Integrated Biological & Behavioral surveillance (IBBS)	Intermittent	NACO/SACS
	3. HIV Estimations	Intermittent	NACO/ICMR/SACS

A robust monitoring system has been put into place to assess the performance of CSO partners. Monitoring of the TIs is carried out as per the stage of scale-up of the intervention.[64] A computerized management information system has been developed through which CSOs submit monthly performance reports. A quarterly analysis is provided by the SACS as part of progress and feedback to the implementing partners to guide them in their subsequent planning.[65]

Evaluation About halfway into the project's duration, a midterm Programme Evaluation is conducted by an external agency. Programme Evaluation of TIs is carried out to assess the effectiveness of the programme and to develop plans for sustainability through a panel of external evaluators once in every two years. In addition, Behavioural Surveillance Survey and

Bio-Medical Survey are carried out periodically to track trends on high risk behaviour of selected groups. In the case of CBOs and networks, criteria are generally relaxed early in their life so as to offer them the time to settle into the programme. Priority has been given to translational research to enhance the knowledge and evidence base for the HIV response for an accelerated progress towards achieving Ending of AIDS by 2030.[66]

Administrative Structures

Well defined administrative structures have been put in place for the NACP that begin at the national level and reach as far down as the district level. The chief body overseeing the work of the NACP is NACO. NACO is located in the national capital of Delhi and is an entity of the MOHFW, Government of India. The role of NACO is to formulate national policy with respect to the HIV/AIDS situation of India, develop guidelines for an effective and efficient response to the epidemic, and ensure that the state and districts have the manpower and financial resources to carry out their tasks. NACO is assisted by the National TSU which supports the TI component of the programme countrywide.

SACS are quasi government organisations set up to translate the administrative role of NACO to the state level. SACS are established to manage and implement HIV activities in the respective states, driving more decentralised, strategized and focused activities.[67] Because both NACO and SACS have been set up under India's Societies Registration Act, the arrangement has provided the flexibility to move money very rapidly to the field level. TI 'projects' are contracted, funded and monitored by SACS. SACS are differentiated in size, based on number of TIs being funded in the state. A major structural reform has been in constituting District AIDS Prevention and Control Units with a team of field functionaries in high priority districts of the country. The main objective of these units was to put district-specific initiatives in place, take up activities to integrate with formal health infrastructure, and carry out mainstreaming with the other departments in the district.

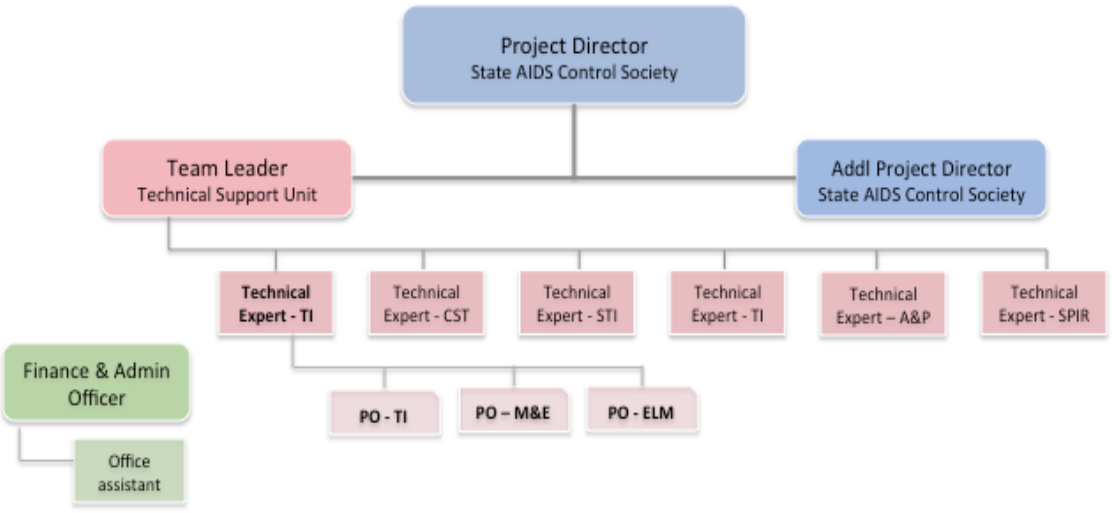

Figure 8: Structure of SACS and TSU

In light of the importance that TIs hold in the preventive programming of the NACP, TSU have been created to enhance the capacity of the SACS to effectively manage CSOs. First implemented in a limited number of states, these were formalised and expanded to cover all states in Phase III of the NACP.[68] TSUs were envisaged to oversee the quality and mentor and support TIs in the states in conjunction with SACS.[69] The remit of the TSUs includes evidence based strategic planning and resource planning, capacity building, visits to CSOs that implement TIs, and activities related to the strengthening of TIs.

> The capacity building of non governmental organisations must be continuous so that their skills are constantly updated, be it in programming, communication, monitoring and governance. This requires a lot of inputs from outside as well as inside.

The TSU supports capacity building of the implementing CSOs. It undertakes supportive visits to partner organisations and provides coaching and mentoring to NGOs and TI staff. It participates in periodic reviews of the partner organisations and provides necessary inputs to improve their working. Thus, TSUs play a key technical role to assure the quality of TIs, serving as the "eyes of the SACS". The TSU implements TI in the respective state along with SACS and partner organisations by following guidelines developed by NACO. The creation of TSU is a revolutionary concept in public health, where an outsourced technical wing provides technical inputs to the programme so that health managers are free to concentrate on managerial activities. In short, SACS focuses on implementation and TSU on quality assurance.

Role of SACS	Role of TSU
TI contracting	Facilitate development of TI proposals and workplans
Program administration	Provide supportive supervision and handholding support
Quarterly and Regional Review of TIs	Analyse TI data and give feedback on key indicators
Fund flows	Ensure transparent accounting
TI evaluation	Analyse evaluation reports and incorporate findings into TI workplans
Handling inquiries (RTI, other queries)	Strategic planning and problem solving

Figure 9: Role of SACS and TSU

Organisations of repute have been engaged as State Training and Resource Centres to conduct capacity building activities for the TI programme in each state. Training and capacity building is carried out at these Centres to ensure standardised curriculum and quality training to different categories of staff working at NGOs and CBOs.[70] Further, the State Training and Resource Centres also conduct training for managers in the programme, ensuring that both the technical and managerial aspects of the programme receive attention.

Social Contracting – what really makes it work

Communities have been placed at the heart of the programme.[71] Community-led initiatives allow members of the community to play the role of a pressure group as consumers to maintain and reinforce quality of services, leading to sustained demand for high quality services. The NACP design aims to strengthen the processes of community-led and community-owned TIs. CSOs are involved at various stages of the programme. They participate in the programmes by identifying peers at high risk, undertake delivery of services and are responsible for monitoring of programmes. In addition, members of the key populations have been engaged to provide leadership, support policy and programme design, undertake outreach as well as perform other functions as part of the TI service provision.[72]

> Social contracting has worked well because of the tremendous mutual trust between the government and the implementing civil society organisations. Involving key population representatives in policymaking, executive and technical committees that steered implementation design not only built this mutual respect but also made the interventions more robust.

Community-led interventions leverage the existing organic bonding among community members so that individual members take interest in supporting their colleagues in accessing both information and services.[73] This leads to rapid and saturated coverage of the communities. For example, when the Sonagachi project, started by the All India Institute of Public Health and Hygiene was handed over to DMSC in 1999, the organisation was able to expand to 15 red light districts in the state of West Bengal in a span of only two years, increasing the coverage of the FSW population in the state from 5000 FSW to 40,000 FSW. DMSC has been repeatedly documented and remains one of the world's most successful models of social contracting.

However, it should be pointed out that not all communities were well organised from the start. Just as the DMSC was formed through hard work, other FSW communities had to be created all over the country to ensure that they could be reached and mobilised. Particular challenges were faced in collectivising MSM and transgender communities as they were often not 'out' to their families and friends. The *Hijra* were already a well organised community, but guarded against offers to support them. It may be noted that collectivisation posed threats to the existing power structures within these communities, and empowered individuals leading to apprehension among many leaders.[74] The IDU needed the greatest effort to collectivise, and even today, their community-led interventions pose the greatest challenges. For those who were not socially outcast such as the truckers and single male migrants, this approach was not attempted, since a common binding narrative was even less likely.

As A People Stronger (2010) notes: "Some organisations addressed in the first instance, the imperatives of high risk sexual behaviour, others of civil/human rights. But their goals were the same. The former took sexual health issues as the basis, shaped its agenda around addressing risky behaviours, and used such intervention as an entry point to wider issues. The latter engaged with civil/human rights issues, seeking to empower these sub-populations to take control of their own sexual health problems. Both processes form an

important part of community collectivization and mobilization and have led to gains."[75]

Trust Another key prerequisite of a social contract is trust and openness between the CSO and the government. Because of the unique threat posed by the HIV epidemic to the lives of those most at risk and the directness with which the government offered to work with affected communities, the social contract became not merely a transaction between two parties, but a pact of confidence. Experts have argued that without this element, NACP would not have been able to achieve the singular success that it has. First, because these communities lie at the edge of society, they had a trust deficit insofar as the government was concerned. Co-opting them to a government programme was a challenge. Second, significant changes were being sought to their lifestyle, both personal and professional. Third, the government needed to be convinced that the communities would take the threat of HIV seriously enough to take the precautions needed. And finally, the ability of these communities to organise themselves into CBOs, collectives and networks was yet to be proven. Still this partnership between the government and CSOs worked because of the mutual trust and respect that gradually developed between them and came to full flowering in NACP III.

> Connecting with community based organisations, and for community based organisations with communities takes time. There cannot be a rigid time line to create a connect with the communities.

In the context of the HIV programme in India, NACO made concerted efforts to gain the trust and respect of NGOs/CBOs by creating social spaces and forums for the marginalised and criminalised populations such as FSW, MSM, TG-H and IDUs either through legal means or by raising awareness and acceptance for them through information campaigns.[76] Furthermore, NACO's earnest engagement with HRGs aided in developing first and second generation TI leaders and champions as the programme evolved under NACP.

An Evolving Value Proposition

Social contracting has offered an evolving value proposition to India's HIV/AIDS programme. Its value has corresponded with changes in the nature and dynamic of the epidemic. In the early days, the critical question was about how to reach the populations that were bearing the brunt of the infection. DMSC offered a beacon of hope to the programme that then began to seek out NGOs and CBOs working with these three communities as a channel through which services could be provided. The involvement of CSOs continues to be the core of the prevention component of the NACP today.

> Key populations became an intrinsic part of the changing value proposition.

The reliance on large well established NGOs progressed into working with smaller CBOs, collectives, networks, etc. This movement required a huge change in mind set. As the programme sought to gather more and more of the communities into its fold, it became heavily invested in CBOs. There was a shift of focus of capacity building from NGOs to engaging the community and from there to building the capacity of the community itself to

mobilise and collectivise. CSOs started to rely on peer educators to bring about behaviour change rather than on project workers who did not belong to the community.

The social contracting model also fostered the creation of an enabling environment. Unable to reach the stigmatised populations on their own, NACO had to partner with CSOs to do so. In doing so, the partnership transformed to one of equals. Civil society voice became stronger over the years and it was provided the space to influence policy and programme decisions. As the programme matured, CSOs found a place at the policy table.

Working with key populations brought about a change in the moralistic and judgmental attitudes and mind sets of those working with them. Instead of viewing them as immoral and criminal, their rights were recognised and placed at the centre of the programme. The programme thus matured from a harm reduction to an empowerment and rights-based approach. This thrust on empowerment was maintained to create an enabling environment so that there is a greater acceptance of infected and affected people by society today.[77]

> The populations we are targeting are high risk, stigmatised, hidden and difficult to reach. So it is best to approach them through civil society organisations that they trust. Trust is key here, and can only be built with organisations that show they are interested in the betterment of the key population.

Mutual confidence between the government and community has been fostered by several progressive efforts of the government. Criminalisation of communities has been challenged in court by activists and supported by the programme in order to ensure a better life for all. As an example, NACO supported a Public Interest Litigation case filed by a NGO in the Delhi High Court in 1991. Seeking to repeal a provision of the draconian 19th century Section 377 of the Indian Penal Code[xi] that criminalised same-sex sexual relations between consenting adults, this case became a *cause celebre*. Despite strong political pressures to withdraw the case, NACO spearheaded by the Health Minister of that time, stood their ground and their affidavit stayed unchanged.[78] Following a protracted struggle, a favourable outcome was finally achieved in 2018. Permission is now available for persons who inject drugs under the Narcotic Drugs and Psychotropic Substances (Amendment) Act 2014 to be managed for drug dependence by legitimising opioid substitution. In 2019, Parliament approved the Transgender Persons (Protection of Rights) Bill prohibiting discrimination against a transgender person.[79] NACP took into account the lives of persons belonging to the communities and worked not only to reduce transmission of the virus, but also to address the aspects of their lives that made them more vulnerable to exploitation and abuse.

The programme also led to effects in the populations themselves. Many in these communities were loners, many still in the closet in the face of punitive laws, and many others living double lives in order to maintain an acceptable social identity. Where communities existed, they were small and fragmented and vulnerable to dispersion at the hint of dispute. The HIV epidemic presented a collective threat to these divided communities

[xi] Section 377 of the Indian Penal Code reads as: "Unnatural offence: Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."

and gave them the reason to coalesce and mobilise against a common foe. This required many years of hard work, but one that the NACP fully supported and encouraged. Joint action by communities took place more and more as the programme matured, excesses of pimps and the police were challenged, social integration was sought out through financial inclusion, and many communities chose to organise into CBOs.

Social contracting works because of the sense of community. A community identity gives a sense of belongingness, a precondition for mobilisation and collectivisation that can empower and enable the disenfranchised and discriminated to change their risky behaviours and situations.[80] Collectivisation stimulated a transformative self-development in the individual and community. This, in some cases, resulted in forming of CBOs that owned and led programmes rather than NGOs or government. The government on its part took big strides from a point where it had no formal plan for engaging NGOs and CBOs, to the point of preparation of specific guidelines and systems for contracting NGOs, CBOs, collectives and networks, as well as allocating funding to them.

In sum, in order to build an effective partnership, a healthy respect must be developed, taking into account the other's mandate, abilities and limitations.

Chapter IV
Learning from the HIV/AIDS Programme

The HIV/AIDS epidemic has changed our lives forever. Bursting upon the world stage, the tiny virus has had far reaching effects not only in terms of the country programmes instituted to fight it, but it has also caused societies to re-examine the structural norms and beliefs that underpin them. In India, significant financial investment has been made to address the epidemic, institutional responses instated, and laws repealed or amended. Now at the start of its fourth decade, India's formal response to the epidemic continues to expand and evolve to provide prevention, testing and treatment services across the country. This section synthesizes the results achieved, challenges faced and lessons learned from social contracting to better inform the future course of action.

It is no surprise that India's programme for the control of HIV/AIDS is well regarded. During the course of its journey, it has achieved a remarkable decline in new infections of HIV. Together with the provision of ART, this has ensured a major reduction in the number of AIDS-related deaths. But the response has also had several other achievements, many of which will play a part in the ultimate goal of defeating the epidemic. Social contracting has played a vital role in the response to HIV in India. As a public health challenge, the HIV epidemic posed particular challenges to awareness, reach, coverage and utilisation by those that needed intervention the most.

Value Addition of Social Contracting

India adopted an intervention approach that targeted services to the most at risk populations through CSOs that understood them. HRG were the object of punitive laws and policies, keeping them underground and difficult to access.[81] Reaching these hardest to reach and invisible populations was best achieved by CSOs who had deep links with the groups and used strategies developed from their deep understanding of these populations. The concept of TIs is unique to the Indian programme and represents its investment in an approach that mobilises communities in order to help them, and focuses services on the population sub-groups that most require them.

> If today, we have 99.8% of the people of India living without HIV, there is a reason behind it. Clearly social contracting and the Targeted Intervention structure has helped to keep people HIV negative.

The government did not have any prior experience of working with populations such as FSW, MSM, TG-H, IDU or others. CSOs provided the space and platform to work with them. Owing to the morality attached to behaviours and practices of these populations, not everyone wanted to work with them. To work on sensitive and intimate issues on a large scale, required close

involvement and mobilisation of affected communities. Thus, social contracting was instrumental in reaching populations that could not be reached by government programmes.

Another value added by social contracting to the HIV response in India was in providing services and social mobilisation. Fear of transmission in healthcare settings and stigma and discrimination on the part of mainstream health providers were barriers that key populations experienced in accessing and maintaining contact with health services. This pushed CSOs to take a leading role in advocating for health services, providing peer outreach and community mobilisation.

This highlighted the need for a strengthened role for civil society in the planning and implementation of programmes and services and in particular, bringing to scale effective key population engagement programmes. This was evident from the participation of community representatives in planning meetings during various phases of NACP whether in the Working Groups at the beginning of NACP Phases or the Technical Resource Group meetings spanning across all programme components of NACP. Social contracting was instrumental in shaping public health policy, governance of country and local programmes, as well as in leading advocacy for reforms that reflected rights-based approaches. Many feel that the biggest value of social contracting was to make place for CSOs at the policy table. Thus, social contracting was able to extend and expand the reach of government-led health systems, adding value to HIV prevention efforts and supporting PLHIV.

A Rewarding Journey

The journey that the national response to HIV/AIDS has travelled has not been without challenges. But there have been modifications and corrections; all in all, the response to the epidemic has been a journey of learning. Social contracting has remained the mainstay despite all the other important issues that the programme has had to grapple with.

Evidence At the start of the epidemic, little was known about HIV/AIDS. Its long incubation and the protracted illnesses that it caused leading inevitably to death, triggered fear amongst the public. Limited data posed a challenge in locating and identifying the infection and its transmission in the country. This led to delays in a formal, pointed response to the epidemic. However, as the initial panic reaction was belayed, effort was made to collect data. This evidence provided the basis on which the national response could be launched in the country.

With an evolving epidemic, the evidence base has also needed to evolve. A key factor that assisted the NACP in making the gains that it has, is its investment in operations research to get a greater understanding of the epidemic. Research was used to reveal the diversity of the needs of the key populations, and pilots to fine tune the response. For example, research on where and how interactions are brokered between MSM led to a better understanding of how the response might be shaped, while the piloting of an MSM TI suggested how the community might like to receive the services. It highlighted for example, how important community mobilisation is and how it could be done; that lubricants would

be required if effectively protected anal sex was to be practiced; and that changing patterns in how FSW approach and recruit clients had implications on how the programme reaches out to them.

Stigma and taboo With data trickling in about the spread of the infection, sexual transmission was highlighted as the leading factor. HIV/AIDS took on the same stigma and taboo that were historically associated with the STIs. But the exponential rise of cases among those most at risk galvanized the authorities and they launched a national programme that put prevention at the heart of the programme. A critical aspect of the prevention strategy has been to connect with CSOs in order to reach the populations most affected by the HIV infection. As HIV is concentrated among stigmatised and hidden populations, to bring them into the mainstream is challenging. It was clear to the programme that the marginalised key populations had to be empowered and supported to give them the confidence and tools to change their risky behaviours.

The first step was to offer an identity to the key populations based on their common experiences, concerns and needs. This sense of identity created a feeling of belonging and a shared faith that the needs of the members will be met through their commitment to be together. By claiming their identity, the key population began to see themselves as part of a community with greater power to bargain for their rights and access to services. This helped to build a social movement where the community collectively exercised their rights, as an authority and became equal partners in the planning, implementation and monitoring of HIV services.

Personal belief systems The HIV/AIDS epidemic had a much more subtle, secondary effect. Because of the sexual mode of transmission and uncovering of sexual networks in the country hitherto not overt or spoken of, it made speaking of sex, gender and sexual relations no longer a taboo. In particular, discussion of the experience of gender of MSM and TG-H and the exploitation of FSW by their pimps and brothel owners provoked a discourse on sex and gender in the country. At the same time, the epidemic garnered social acceptance for populations with different vulnerabilities and sexual orientation.

The epidemic also brought about a big change in the mindset of people working in the sector. The HIV programme gave visibility to marginalised and stigmatised populations who until then had no reason to approach the mainstream. The affected communities were given a platform to present and share their concerns, needs and demand their rights. Adopting a non-judgmental approach on the issues of morality made people transform their personal ethics and values and become more accepting of differences. People went from ostracising key populations, to not judging them, and going further, to treating them as partners.

Legal framework Over the years, data showed the infection was disproportionately prevalent in certain populations that were socially and politically marginalised and criminalised. The socio-political environment posed a great challenge to NACO's harm reduction approach with FSW, MSM and IDUs. The nodal Health ministry and NACO and ministry of Home and Social Justice and Empowerment ended up being on opposite sides of the spectrum with respect to laws that pushed IDU, FSW and MSM further underground.

To address the ideological divide, continuous engagement and dialogue with the ministries was undertaken. Presenting evidence and data on solutions endorsed and designed with the expert inputs of scientists, epidemiologists, academicians, donors and CSOs, NACO with the support of the Health ministry, was able to get an endorsement for their strategy. This coupled with strong activism by CSOs, resulted in change in many laws and policies that made the environment more conducive for prevention efforts with the most vulnerable populations. One such was the overturning of Section 377, an out dated law criminalising consensual sex between same sex couples. A long-awaited legislation, the HIV and AIDS Prevention and Control Act, 2017 that aims to end stigma and discrimination against people living with HIV in society, healthcare settings and workplace, while also ensuring their privacy, was enacted in April 2017.

Institutional capacity A key limiting factor for a full and well developed response to the epidemic was the sheer lack of experience with the epidemic. There was the need for state level government actors to develop their own capacity to act as a resource. Complicating the process were state differences in both the health system capabilities and in the behaviour of the key populations. An important response to the HIV epidemic in India was the early development of a designated autonomous entity NACO, linked to the MOHFW. Recognising the threat that the epidemic presented, a Project Director of the senior rank of Additional Secretary to the Government of India was designated to head the entity. This allowed it to receive crucial international funding in the early days when the contours of the epidemic were much less clear and the scale of response needed unknown.

The role and involvement of the states also changed. With the threat of a devastating epidemic looming over India, the institutional response was expanded to the state level in phase II of the programme. SACS set up at the state level provided the much needed state level focus to the response and ensured that the response was localised and contextualised. Technical support for a robust TI programme was identified as a need and TSUs were put in place. The need to have a district level presence to coordinate and link the various activities of NACO could no longer be ignored, and in phase III, district level units were established.

Technical capability The newness of the infective agent, the lack of information about its spread and the lack of blueprints for a response made the epidemic particularly challenging. Because of the *modus operandi* of the virus, a clinical response was not sufficient, certainly not one that was located entirely in the public sector. Further, these marginalized populations did not access public health services. This meant that a fresh way of dealing with the situation was required; one that fostered much needed technical, social and administrative skills in raising awareness about the disease, understanding high risk behaviours and undertaking primary prevention among the group. With support from technical agencies, NACP developed a framework and established a consortium of partners to identify strategic areas and work on strengthening human, organisational, and institutional and communication capabilities.

Globally, the UN system put a new agency UNAIDS, into place to coordinate the UN's response to the situation and assist countries to take up the challenge. WHO and World Bank consultants and advisors were instrumental in guiding the initial response. Bilateral

partners such as USAID and DFID also played a major role in the early days of the response, developing and testing solutions for the ground. A new funding mechanism – the Global Fund against AIDS, TB and Malaria was created. PEPFAR, a technical partner since 2003, provided technical support along the prevention to care and treatment continuum under the Cluster Strategy.

Grassroots partners As the country came to grips with the epidemic, the challenge became to identify the right NGOs and CBOs to partner with in the prevention efforts. Identifying NGOs with the required capacity, experience and skills was not an easy task, especially when the government's own systems were still evolving. CBOs were not yet in place, and to set up a CBO and build its capacity is time intensive, requiring continuous interaction of 2-5 years in a social contracting model.

The programme recognized the challenge and focused on organisational development to ensure that CSOs have the right leadership and other skills needed to partner in the programme. Networks were encouraged and system support was deliberately put in place. Detailed guidelines were developed, and the government took a consciously developmental approach that included handholding and mentoring by those with prior experience. Systems were developed that built this flexibility into its core. Sustaining social contracting will require on-going support and collaboration.

Testing A key to effective control of an epidemic is to know who is infected and to ensure that the infection does not spread from that 'case' to another. The identification of people with HIV is the first step, ensuring their awareness and carrying on to their linkage to treatment services.

To address this, the national HIV testing guidelines have been revised over the years to keep pace with the global guidelines that recommend client-initiated voluntary counselling and testing, and provider-initiated testing and counselling for pregnant women, people infected with TB and STI patients. Under the NACP, a network of stand-alone, mobile, facility-integrated and public–private partnered ICTCs have been established across the country to provide HIV testing and counselling services. In the new strategy, index testing has been included to increase the reach and testing coverage of sexual partners, spouses, social and injecting networks of the index client. An index client is a person from an HRG who has been diagnosed as being HIV positive. HIV testing for the partner is done through either voluntary or assisted partner notification after ART initiation and stabilization. The new approach of Community Based Surveillance has been included to improve early diagnosis, reach first-time testers and persons who seldom use clinical services.

Basket of services Defining the package of services and activities for a widespread epidemic in a country as large as India was a big challenge. The basket of services was not always clear. In a pleasure-oriented set of activities, there were animated arguments at NACO about the distinction between public and private goods. For example, when MSM and TG-H groups demanded lubricants, there was a lively discussion on whether this was pertinent for the programme to supply. NACO recognized the value of broader support for HIV prevention and encouraged linkages with care, support and treatment activities. However, to enable the

linkages, it first needed to identify the detection and treatment gaps in high-burden areas and key affected populations[3].

In the end, only with the recognition that lubricants would reduce the micro-abrasions and tears that promote infection, did the programme agree to provide lubricated condoms. Nevertheless, there continued to be argument about whether the resources provided were effective and appropriate. Designing this basket was a tightrope walk between needs, resources available, and ability to operationalise.

Care, support and treatment As the epidemic has matured, the need for care and support systems and ART have emerged. These additional components were added to NACP to respond to the changing and growing needs of the affected populations. Providing access to free ART helped to enhance trust in the system. Over the years, the treatment component has been scaled up through various models of service delivery that have ensured continued access to free ART to those in need. The provision of treatment has encouraged more people to come out to seek testing and connect with the National AIDS Control Programme. Additionally, access and adherence to treatment has not only resulted in improving the quality of life of PLHIV but also reduced AIDS-related mortality. This is evident from the reduction in AIDS related death rates.

In turn, this has provided an opportunity to connect with more affected and infected members from the communities and provide them the gamut of services for prevention, care and treatment. Integrating care and support with prevention services through PLHA networks has ensured that services reach not only the HRG populations who are HIV infected, but also their partners and or spouses who are at elevated risk to the infection.

Resource mobilisation To carry out the large scale prevention, care and treatment efforts, and a huge mobilisation of resources has been required. However, middle-and low-income countries have faced challenges in meeting the funding requirement on their own. To address this funding crisis, the Global Fund Against AIDS, Tuberculosis and Malaria was created in 2002 as an international financing organisation that works in partnership with governments, civil society and people affected by HIV (in addition to malaria and tuberculosis). The Global Fund has been instrumental in supporting key population efforts.

At the height of the epidemic, India had the good fortune to have over 25 donors that stood in support of the country's efforts. The World Bank has provided over USD 750 million over 20 years of HIV/AIDS programming through soft loans. The Global Fund supports India with investments to help meet its goals. Over the years, the proportion of the national programme funded by the domestic budget has grown. As the World Bank ceases its funding of the programme in India, domestic funds will be allocated to financing the critical component of TIs.

Sustaining Social Contracting

In the initial years of the epidemic, the rapid rise in HIV infections in the country caused great concern and fear about its potential uncontrolled spread. India was considered to be

an epicentre of the global HIV/AIDS epidemic at the start of the millennium. At that time, analysis projected that by 2010, 20-25 million people could be living with HIV in the country. This would have made India the country with the largest population of people living with HIV in the world.

However, with a steadfast focus on prevention as the mainstay of the national programme, new infections showed a decline and the spread of HIV infection was stayed. The last decade witnessed a 50% reduction in new infections resulting in a big drop in the projected numbers of PLHIV. This has resulted in keeping over 99% of the Indian population uninfected.[82] In 2017 there were 2.1 million PLHIV, ten times fewer than the 25 million projected.[83]

At every stage of the national response, important lessons have been learned from the results achieved and challenges overcome. Strategies and processes have responded to these challenges and moved forward while remaining rooted in the social and behavioural context in which the epidemic fires are burning. Evidence shows that social contracting has been integral to the achievements and has helped to overcome many challenges along the way.

A well established and effective HIV prevention effort targets those most likely to acquire and transmit HIV. Such a programme is focused on the main drivers of the epidemic, namely, high risk sexual behaviour and injecting drug use. Key populations for HIV-infection continue to be FSW, MSM, TG-H and IDU. If the programme is to achieve the ambitious target of 100% coverage of these groups, social contracting has to continue as the mainstay of targeted prevention interventions.

As we have already seen, a key ingredient of the mix is a continued trust in NGOs and CBOs as indispensable partners in helping to achieve programme goals. Effective partnership requires consultative processes and inclusive approaches and these will need to continue to ensure transparency and goodwill. Continued effort to build and support capacities of both NGOs and CBOs is critical to successful reach, implementation and achievement of programmatic goals. There are challenges of two types: first, enough trust has to be reposed in the communities to allow money to be transferred to them; and second, the financial management system must be flexible enough to ensure that they are never starved of funds.

Implementation success will require identification of new sites of frequent, high risk behaviour, physical and virtual, through mapping and routine tracking of programme coverage and impact. Valuing inclusion and being sensitive to the needs of the affected communities will have to be the bedrock of the programme approach. Continuing to find innovative ways to mobilise communities will be integral to prevention efforts. However, community mobilisation efforts require time to build trust and confidence. Programme timelines needs to allow for such ground realities and be flexible insofar as the capacity building needs of individual CBOs or networks are.

As social changes take place, communities shift and change their practice. New members join the community and others leave. The members reached by present TIs are now well informed about the disease, have grown older and have chosen to adopt a less risk-taking

lifestyle. It is essential to bring in new and younger members of the HRGs into the fold of the TIs. Young and new entrants into sex work and drug use that are not within the TI coverage area must be identified. Effort needs to be put in to design strategies to reach out and connect with younger and new HRG members.

It is important to be cognisant of the fact that over the years there has been a significant change in the location and working of some of the key populations. For example, sex work has moved from street based and brothel based locations to lodge or home based. Evidence has shown that there are changing trends in sex work dynamics. For MSM and TG-H population, physical spaces have moved from open 'cruising sites' to select clubs, parties and online platforms such as dating sites. As 'hot spots' have changed, the programme needs to keep pace with these changes for improved coverage of the populations. This is possible with the involvement and support of CBOs who have better reach and contact with these groups as compared to NGOs. Training could be organized by NACO to help CSOs develop the soft skills to reach 'tough to reach' populations. Strategies also need to be piloted to reach key populations at other potential 'hot spots' such as massage parlours, spas, those on social media and dating sites and other related online platforms.

In many cases, physical 'hot spots' have evolved to mobile and virtual spaces. These spaces are seen to be more risky than the traditional physical spaces in which transactions took place. For FSW, soliciting or contacting clients is now possible over mobile phones and through social media networks and groups such as WhatsApp that work through a network provider. For MSM and TG-H communities, in addition to mobile phones and social media, virtual spaces offered *via* the internet, such as online chat rooms, dating sites etc. are emerging as preferred platforms for at-risk groups, increasing their vulnerability and risk. Outreach strategy needs to be remodelled to meet these changing realities. For this, there is a need to understand the virtual platform, how people meet, and how transactional sex is taking place. Research and pilot projects are needed to build the evidence base to reach these populations. Virtual prevention messages, counselling, leveraging NACO Helpline 1097 can help to inform people where they can access testing services, get condoms, or go for STI diagnosis and management and link them to services. Both saturating outreach at physical venues as well as reaching out to at-risk population on virtual platforms would need to go together to provide the services such as risk assessment, counselling and linkages to services such as HIV testing, provision of condoms, treatment and care services.

For this, visibility of the programme is important. Use of new and creative media to reach a wider audience is required. Communication campaigns are needed that are contemporary and appealing to the youth. Use of IT applications such as mobile apps to provide basic information about services for HIV prevention and treatment are being explored. TI projects can be provided with mobile units to increase their reach and improve awareness among the general public and targeted populations. This will add as an incentive for the NGOs as well by providing them an institutional resource. In addition, it will enhance their acceptance with the communities as people will start associating them with government programmes that are working for their benefit.

Guidelines and operational procedures are in use to ensure partner and programme accountability. However, rigid implementation of this framework does not take into account the ground realities. Guidelines must allow flexibility in approach and use in recognition of regional variations across the country. For example, different approaches are needed for the IDU population as per the realities in different settings. For example in the north-eastern part of the country, IDUs are home-based and not street-based as in northern and southern Indian settings. Strategies and activities to reach IDUs in their homes need to be different from those adopted for street based outreach based on stability and treatment adherence. Mobile OST delivery can also be explored to reduce drop-out rate. In some areas in the north-east, innovations are being tried out by promoting secondary distribution of OST in *paan* (local) shops closer to the homes of the targeted population. Experimentation is also on to provide 'take home doses' of OST. There is need to consider providing auto-destruct syringes to prevent re-packaging and re-use of the syringes. The operation timing of ICTC and OST centres may need to be modified to enable better access by IDUs. Innovative strategies are needed to maximize reach to the affected populations by risk and vulnerability. Recognising this need, NACO undertook an extensive consultative exercise to review, revamp and revise its TI strategy to increase coverage and quality of services being provided. The revised TI provides a renewed focus on hard-to-reach populations and the unreached HRGs living outside the TI geographic areas.

Accountability frameworks to monitor and evaluate partners must permit flexibility in order to encourage innovation. Supportive supervision that has greater understanding and sensitivity to the needs and capabilities of partners and handholding support to build capacity is essential. Experience sharing by providing space and time for NGOs and CBOs to meet and discuss innovative approaches to address challenging situations will go a long way in building capacities as well as support networks. Exposure visits to TIs or demonstration sites in other settings and states will encourage cross learning as well.

Prevention focus also needs to expand to include ART for people living with HIV. Earlier, while prevention was seen only through condom promotion and distribution, it is important to include testing and ART initiation if a person tests positive. This will prevent onward transmission. This calls for an expansion in the TI approach to combine with testing and training facilities.

At the same time, scaling up HIV prevention and treatment to reach the prioritised and unreached requires adequate funding. With restricted funding, the programme implementers have learnt to ‘do more with less’. However, retaining project staff with minimal pay and on old pay scales is difficult. Delays and problems with fund flow result in interruption of work on the ground. Mechanism to explore release of funds for at least six months to NGOs at the beginning of the year, with the other six months’ allocation in the pipeline. Ensuring adequate funding for priority activities is essential. Further, improving pay scales and prompt disbursal of funds to the NGOs and CBOs needs to be explored to reduce attrition of staff and delays in programme implementation.

It is essential to provide integrated services and linkages with other health and social benefits for the key populations and PLHIV. For this, on-going and sustained networking and

mobilising other ministries, industries, corporates and private sectors is required. A comprehensive multi-sectoral approach requires time for negotiations and advocating for support and buy-in.

> The national programme has really pushed to see that the key populations are at the centre of the response. This is best practice and is being shared with people in the US and Africa. The ownership of the government has yielded clear results in India.

With additional well-led initiatives, political commitment, active engagement of civil society, and additional funding, India can realize the vision for eliminating the impact of the AIDS epidemic. Planners, programme administrators and implementers must utilize the knowledge and resources that are generated and made available. To aid in achieving this goal, it will require acceleration of current efforts and scale up of innovations in order to change the trajectory of the response.

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ANNEXURE I

LIST OF EXPERTS CONSULTED

Expert	Present Affiliation
Abou Mere	Kripa Foundation
Alka Narang	Independent
Akhilesh Singh	Saarthi Foundation
Alok Kumar Verma	Lok Seva Sanstha
Altamesh Khan	Helping You Foundation
Arif Jafar	Naz Foundation
S. Arivalagan	TANSACS
Arumugam Vijayaraman	TAI-VHS
Ashok Alexander	Antara Foundation
Ashok Row Kavi	Humsafar Foundation
Bhawani Singh	NACO
Bilali Camara	UNAIDS
Deepak Jacob	TANSACS
G. S. Shreenivas	Family Health International
Himanshu Porwal	Helping You Foundation
Jasjeet Kaur	UPSACS
JVR Prasada Rao	UNAIDS
K. Sudhakar	Independent
Matangi Jayaram	Independent
Moses Pachuau	Indian Drug Users Forum
Nandini Kapoor Dhingra	UNAIDS
Neeraj Dhingra	National Vector Borne Disease Control Programme
P. K. Khare	Natural Care
Ramesh Srivastava	UPSACS
Shobini Rajan	NACO
Shubhra Tandon	CREATE
Smarajit Jana	Sonagachi Research and Training Institute
Suhail Mohammed Ali	UPSACS
Subhash Ghosh	YRG Care
Sujatha Rao	Independent
Sundar Sundaraman	Independent
S. Swaminathan	TANSACS
Suresh Mohammed	World Bank
Thangaraj Ilanchezhian	TAI-VHS
V. Manimaran	TANSACS
V. Velaiah	TANSACS

ANNEXURE II

INDIA'S EXPERIENCE WITH SOCIAL CONTRACTING

Previously termed NGOs, the term civil society entered the public discourse in India in the 1980s with a rise in the number of NGOs and other voluntary associations. The Indian government recognised the potential of its robust civil society sector and encouraged collaboration and engagement with them. It was during this time that the involvement of NGOs in provision of health services in India gained momentum as the focus on participatory approaches through public-private partnerships formed key strategies of health sector programmes.[84] There are varied experiences of social contracting for empowering communities, encouraging participation, strengthening democratic institutions and improving access to basic services.[85] Social contracting is not limited to the HIV/AIDS programme, having been used in India in the family planning, blindness, TB, and health insurance programmes. In this section, some examples of social contracting from both the health and non-health sectors are presented to expand on the way it has been used.

The role of civil society in the family planning programme in India is well documented. Since it was adopted in 1952, the programme implemented a number of different strategic approaches that included a coercive target approach, a reproductive health and rights paradigm, contraceptive-specific incentives, and a family planning camp approach. CSOs played an extensive and effective role in expanding service provision and linking communities to the health system. More specifically, they raised awareness, generated demand, offered training, and advocated for an improved enabling environment to ensure that women and men were able to enjoy full, free and informed choice about whether and when to have children. These CSO interventions showed significant contributions to improved access to family planning programmes, increased knowledge and awareness, contraceptive use, and client satisfaction.[86]

India's prolonged battle with poliovirus that ended in achieving the title of a polio-free country in March 2014 also owes its success to social contracting. In the Pulse Polio programme, a consortium of national and international NGOs formed a bridge between communities and the government programme. NGOs mobilised community based volunteers to work with families of young children, school-going children, nursing students, teachers, and key stakeholders to enable demand and uptake of the vaccination. CSOs sought ways to understand misgivings, dispel mistruths and convince communities about the value of immunisation and child survival. As summarized by Roma Solomon (2019), "India's polio eradication programme is a shining example of what can be achieved if civil society is brought into the inner circle of planning, policy making and implementation".[87]

Civil society also played a critical role in the National Programme for Control of Blindness, (renamed as National Programme for Control of Blindness and Visual Impairment) launched in 1976 with the goal of reducing prevalence of blindness in the country. CSOs strengthened, expanded and delivered eye care services in the country, especially in tribal and rural areas. In addition, various financial schemes were made available through public private partnership mode.[88] Similarly, the National Leprosy Eradication Programme, initiated in 1983, achieved

spectacular success in reducing the burden of leprosy. CSOs received grants from the Government of India for communication programmes, prevention of impairments and deformities, case detection and treatment delivery. This helped the country achieve its goal of leprosy elimination as a public health problem.[89] The Revised National TB Control Programme, based on the internationally recommended Directly Observed Treatment Short-course strategy, was launched in 1997 and expanded across the country in a phased manner. TB care services are being provided through engagement of private providers and NGOs. Collaborations have been forged with more than 1800 NGOs and 13,000 private practitioners to enhance the visibility and reach of the programme and engage with communities and community based care providers to improve TB care and control.[90]

Perhaps the most recent example of social contracting in the health sector is the Ayushman Bharat Pradhan Mantri Jan Arogya Yojna or National Health Protection Scheme that aims to cover over a 500 million marginalised and vulnerable families with secondary and tertiary care hospitalization insurance. In the states, the scheme is being implemented by a State Health Agency that partners with an existing CSO or a new entity to implement the scheme.[91]

A non health programme that has depended on social contracting for its successful implementation is the Mahila Samakhya[xii] programme in India. This was launched in 1988 to pursue the goals of the New Education Policy for the education and empowerment of women in rural areas. The programme was built on a partnership between the government and NGOs. Project formulation evolved through a process of consultation and debate with CSOs and women's groups about the role of education in the process of empowerment, especially of rural women and girls. The programme was implemented through autonomous registered societies set up through the programme at the state level. The autonomous structure, flexibility in strategies as well as involvement of people from outside the government has helped make the programme successful.[92]

End Notes

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