



Report on Terminal Evaluation of UNDP Project
“Increasing Access to HIV/AIDS Prevention and Care for
Vulnerable People”

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Executive Summary

The overall objective of the UNDP Project “Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People” is to build capacities of people affected by HIV for increased demand and access to rights and entitlements (including sustained access to medicines). It also seeks to facilitate community action for addressing laws that impede effective HIV response. The Project addresses both the UNDAF / CPAP Outcome¹ and Country Programme outputs.²

This terminal evaluation has been commissioned by UNDP with a view to assess the contribution made by the Project to mainstreaming activities comprising creation of enabling environment, stigma reduction, social protection and partnerships with non-health ministries. The evaluation particularly makes an assessment of the achievements of DAPCU-led “single window” model of social protection and the role of different stakeholders and their contribution towards the single window model. It provides recommendations and way forward.

The terminal evaluation followed the DAC (Development Assistance Committee of OECD) evaluation criteria namely (a) relevance (b) effectiveness (c) efficiency (d) impact (e) sustainability. Two additional criteria were given to the consultant for assessment: value addition and gender (equality). The evaluation was also guided by the UNDP Handbook on Planning, Monitoring and Evaluating for Development Results and its Companion Guide on Outcome-level Evaluation.

The consultant collected information from both secondary sources (like Project documents, progress reports, Project budgets, various guidelines, publications, reports, surveys) and primary sources (through interviews in the field with stakeholders like SACS, DAPCUs, ICTC Centres, ART Centres, TIs, district level administrative departments and networks of positive people). Attempt was made to compare DAPCU “single window” districts with control districts where “single window” is not operational. However, in view of time constraints, this was done for one district only. The consultant could not visit the critical mass of “control” districts and hence relied more on “before” and “after” approach.

The Project, which concludes in December 2017, has made significant contribution to mainstreaming notably in terms of creating enabling environment, legal and

¹ UNDAF / CPAP Outcome: Government and civil society institutions are responsive and accountable for improving women’s position, advancing their social, political, economic rights and preventing gender discrimination.

² CPAP Outputs: (1) HIV/AIDS affected populations experience less stigmatization and have improved access to entitlements and services and (2) Women’s access to public services and programmes is expanded.

policy, by advocating for the rights of the transgender people. This bore fruit when the Supreme Court, in a landmark judgement, recognized transgender as the “third sex” and right to equality for this excluded community. It further gave directions to the government to make provisions for the welfare of this most marginalized community. It is remarkable for the Supreme Court to cite UNDP documents in the judgement. Furthering its work on mainstreaming, UNDP provided technical support to state governments in setting up of transgender welfare boards and drafting TG policies.

UNDP also assisted NACO by scanning all the laws that impede or enable HIV response. This greatly assisted NACO, Ministry of Health in drafting the HIV/AIDS Bill which has since been enacted as HIV/AIDS (Prevention and Control) Act, 2017 (Law No 16 of 2017). The work on legal and regulatory framework to provide effective response to PLHIV and HRGs continued with UNDP supporting the drafting of Operational Guidelines on Transgender People and Operational Guidelines on MSM.

A key instrument of mainstreaming has been the signing of MOUs between NACO and non-health ministries / departments. These MOUs, prepared with the technical assistance from UNDP, aimed to encourage the ministries to make their own workplace policies HIV sensitive and stigma-free, streamline internal health care facilities to include HIV testing and care and to make their social protection schemes more HIV sensitive. By signing these MOUs with relatively well-funded ministries, NACO has leveraged huge amount of resources reaching out to large number of potentially vulnerable people. This indicates that the potential returns to investment on mainstreaming are very high.

The MOUs above are being monitored by Joint Working Groups at central and state levels and are particularly helpful in modifying schemes of relevant departments to make them HIV sensitive. The Mid-Term Review of NACP-IV as well as a Status on Roll Out of MOUs (August 2017) indicate that the progress on implementation of MOUs is somewhat slow and uneven with some ministries / states doing better than others.

HIV related stigma is one of the major barriers to HIV prevention, care and treatment. Combating stigma is thus one of the key components of the UNDP Project under evaluation. This is being addressed through studies on stigma (Getting to Zero), setting up a Technical Resource Group (TRG), drafting guidelines on stigma reduction that will directly help in implementation of relevant provisions of the HIV/AIDS (Prevention and Control) Act 2017, and integration of stigma reduction framework in NACP-IV. Signing of MOUs with non-health line ministries also aims to address stigma reduction both internally within the ministries and also externally by providing services in a stigma-free environment to infected and affected communities.

On the social protection front, the overall finding of this evaluation is that the “single window” model has performed very well and has the potential of becoming a best practice of HIV-sensitive delivery of social protection to PLHIV, CABA and MARPs. The intervention led to improved uptake of social protection, sensitized the suppliers of social protection services, and lowered stigma in some cases where services were sensitively designed. A strong facilitating role was played by NACO, SACS and networks of positive people whose advocacy led to significant modifications in the schemes to make them HIV-sensitive.

The Project is extremely relevant as it directly supports the national policy on HIV as operationalized through NACP of which the current phase IV (2013-2017) accords high priority to mainstreaming comprising enabling environment, stigma reduction, social protection and building partnerships with non-health bodies as a means to mitigate the impact of HIV on both infected and affected persons. The operationalization of provisions under recently enacted HIV/AIDS (Prevention and Control) Act 2017 (Chapter VII, Section 15) will receive a boost from the Project and social protection activities under it. The “single window” initiative is also well aligned with UNDAF and UNDP Country Programme and relevant to achieving their goals on inclusion, equality and human rights. This Project also focused on the most excluded and marginalized groups like transgenders, sexual minorities, PLHIV and exemplifies UNDP’s commitment to promotion of equality and inclusion. The Project has created enabling environment, including legal, for the services to be provided to PLHIV and sexual minorities in a sensitive manner without stigma or discrimination.

The effectiveness of the Project may be gauged from the fact that the UNDP advocacy has led to the Supreme Court recognizing transgender as “third sex” thus paving way for this most marginalized group to live with dignity. UNDP continues to support setting up of TG Welfare Boards and issuing of Operational Guidelines. Overall, UNDP’s contribution to the welfare of TG is seminal. The recognition of transgenders has led to many states initiating exclusive schemes for them. But UNDP should continue to work with civil society and advocate for self-identification rather than subjecting TG persons to biological and psychological screening before issuing them identity cards and granting benefits so that, in the spirit of the Supreme Court judgement, the transgender persons are treated with dignity.

The Project has been effective in improving the uptake of social protection services from “single window” centres. It is reported that so far over 1 million *benefits* have been provided. Respondents also opined that the DAPCU has stronger advocacy power vis-à-vis state governments (through SACS) / district administrations than the NGOs / positive networks and hence the outcome is much better (like modification of schemes, relaxation of eligibility criteria, expeditious processing, simplification of procedures etc). It is our finding that DAPCU and networks working together with synergy is a much more effective strategy than either of them working

alone. The Project has helped position social protection as an HIV impact mitigating strategy at a higher level. However, access to social protection services by MARPs remains low for various reasons: unwillingness to come out openly; high mobility leading to lack of residence proof and other identity documents; and better economic status hence no pressing need for social protection.

The evaluation noted that the Project made strong efforts at building capacity through training of key stakeholders including DAPCU, ICTC, ART centres, CSC centres, and TI centres, on social protection schemes to build awareness and generate demand. In view of the expansion of social protection schemes, revisions in guidelines, need for DAPCU to advocate more effectively, coordinate better and staff turnover, there is need for more training of DAPCU officials. It is understood that NACO is planning refresher training for DAPCU.

The Project was implemented in an efficient manner and both financial and human resources were put to most efficient use. The strategy of embedding technical experts in NACO (working closely with state governments) to provide prototyping support, technical assistance in determining the feasibility of scaling up, technical inputs provided during the HIV Bill drafting, developing the social protection portal has not only been cost-effective but also ensured national ownership and enhanced development outcomes. This practice of embedded experts, who were available to NACO on hand, established UNDP as a credible partner genuinely interested in national capacity building. Recognition and acknowledgement of UNDP support in most government / NACO documents confirms this.

The sustainability of the mainstreaming initiatives under the Project is high as 15 non-health ministries are already on board to collaborate with NACO. The “single window” model of social protection that was prototyped by UNDP in 2013 was scaled up and operationalized in 100 priority districts in 2014 and later scaled up to all 189 districts under DAPCU. That this scaling up was funded by the government out of their own resources and without additional staffing shows the effectiveness of the model as well as strong national commitment to providing HIV sensitive social protection. The Project has also built adequate capacities to sustain activities without external support but staff turnover, new interventions and need to stay engaged with partners and communities necessitate continuous capacity building of service providers and communities.

The Project is rated very highly for leveraging government and non-government partnerships in the most outstanding manner. It tapped into social protection champions and sympathetic civil servants, networks of positive persons, civil society and staff in DAPCU. The Project also made full use of innovative approaches like social protection camps to create demand for services and awareness.

The Project acquits itself very well in knowledge management, a key contributor to

sustainability. A number of products and documents have been prepared to support NACO in their mainstreaming efforts. Mapping and Size Estimation of Hijras and other Transgender Populations in 17 States of India, Operational Guidelines on TG, Operational Guidelines on MSM, the National Survey on Stigma, the Compendium on Social Protection Schemes, the Guidance Note on the DAPCU-led Single Window Model, the Study on TG Welfare Board Models, Uptake of Social Protection Schemes by Transgender Population in India, among others, are first-of-its-kind knowledge products of great practical import.

HIV Sensitive Social protection portal that was a product of this Project is up and running. It is a useful resource providing state-wise and gender-wise information on various central and state social protection schemes. The portal is now transferred to NACO who keep this updated.

A key factor that will contribute to sustainability is the HIV/AIDS (Prevention and Control) Act 2017 which mandates the need to address stigma reduction and provide social protection. Stigma-reduction and social protection activities, as supported by UNDP under the Project, will sustain as these are now directives from the Supreme Court and legally enforceable under the HIV/AIDS Act 2017.

The Project added value to the functioning of NACO by providing technical support to their mainstreaming activities and thus enabling realization of the relevant goals under NACP-IV. UNDP has been in the forefront in mapping TG population, building capacities of partners from national to district level, piloting initiatives, providing technical papers, advocating, presenting evidence and so on. These activities encompassing legal, social, policy dimensions strengthened NACO's hands in effectively mainstreaming HIV and engaging non-health players. The single window model of social protection brought together various partners for a common cause and made government officials more sensitive and flexible to the needs of the infected and affected people as evidenced from the many modifications carried out in the schemes.

The Project did very well on gender equality and the work on promoting equal rights for transgender is ample proof of that. The HIV sensitive social protection portal can be used for searching schemes by gender, including 'third gender'. The portal shows that there are many exclusive schemes for women (like pension for HIV widows) and third gender besides other schemes that are gender neutral. Several schemes also address children (like Palanhar in Rajasthan which includes children of HIV positive parent(s) in the eligible category). During our meetings with networks, women far outnumbered men and were more vocal in sharing their experience with accessing social protection services.

Overall, the Project was a timely and relevant initiative that provided support to NACO in the operationalization of mainstreaming activities under NACP-IV. The outcomes have been remarkable – the Project created enabling legal and policy

environment, contributed to understanding and reducing stigma, worked towards equal rights for the sexual minorities especially transgender, improved uptake of social protection schemes, and positioned social protection at a higher level as a means to mitigate HIV impact. With the rolling out of the HIV/AIDS (Prevention and Control) Act, 2017 and the Transgender Bill, which will eventually be enacted as an Act, there is further work to be done till the PLHIV and high-risk groups are mainstreamed in the society.

Recommendations

1. Since MOUs with non-health ministries is a key instrument of mainstreaming, it is important that the Joint Working Groups meet regularly and robust monitoring system is put in place at the state level to gauge progress and to prevent disjointed response by line ministries.
2. Transgenders are the most discriminated against high-risk group and hence policies and programmes are needed, that go beyond the TG Welfare Boards, to identify meaningful alternative livelihood opportunities for them to wean them away from begging and sex work. UNDP as a champion of inclusive growth is well poised to design appropriate interventions in the next Country Programme (2018-2022) which would be particularly relevant in view of the impending TG Act.
3. UNDP should continue to work with civil society and advocate for self-identification by TG rather than subjecting them to biological and psychological screening before granting benefits so that, in the spirit of the Supreme Court judgement, the transgender persons are treated with dignity.
4. A basic minimum package for PLHIV, which has been recommended in the past³, is worthy of further consideration and UNDP should work with NACO/SACS/line ministries to operationalize this.
5. Taking the above point further, UNDP should advocate for social protection as a preventive strategy highlighting the role of social protection schemes in reducing vulnerabilities and mitigating the impact of HIV.
6. As DAPCUs are likely to remain the lynchpin of the “single window” model they need to be strengthened and empowered with more funds at their disposal for training, monitoring and outreach so that they can perform their mandate as envisaged in *the Guidance Note*.

³ HIV Sensitive Social Protection – A Four State Utilization Study, UNDP and Tata Institute of Social Studies, 2011

7. With growing digitization, there is need to find online solutions to link DAPCU, networks and line departments and promote greater use of Common Service Centres. This will promote efficiency, reduce corruption, ensure confidentiality and strengthen monitoring and database in the delivery of social protection services.
8. Procedural requirements for the infected and affected people are still too heavy and need to be further simplified. While procedures are formulated at the central / state level keeping in mind possible misuse of the programmes and to target them better, SACS needs to advocate for minimizing the procedural burdens by sensitizing the line departments.
9. Many philanthropists and private sector companies are / might be willing to supplement government efforts in social protection and may not know how to go about it or what the needs are. This potential should be tapped and brought within the ambit of DAPCU.
10. It would be desirable for NACO to quantify the benefits of signing MOUs in terms of saving of resources in setting up HIV sensitive health care facilities in the ministries and their associated departments / PSUs.
11. The MOUs signed between NACO and non-health ministries are being reviewed at the state level JWG meetings and follow up action is being taken. It would be useful to document the state level progress (as distinct from ministry level progress) in the implementation of the MOUs.
12. For the future interventions, UNDP should strengthen its results and resources framework with clearly defined baselines, indicators, targets and means of verification.

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Disclaimer

The views expressed in this report are those of the author and do not necessarily reflect those of UNDP.

Acronyms

AAY	Antyodaya Anna Yojana
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
BEST	Brihanmumbai Electric Supply and Transport Undertaking
BSNL	Bharat Sanchar Nigam Limited
CABA	Children Affected by AIDS
CMHO	Chief Medical and Health Officer
CPAP	Country Programme Action Plan
CSC	Care and Support Centres
DAC	Development Assistance Committee of Organization for Economic Co-operation and Development (OECD)
DAPCU	District AIDS Prevention and Control Unit
DTHO	District TB and HIV Officer
F-ICTC	Facility-Integrated Counseling and Testing Centre
FSWs	Female Sex Workers
HIV	Human Immunodeficiency Virus
HRG	High-Risk Group
ICRW	International Centre for Research on Women
ICTC	Integrated Counseling and Testing Centre
JWG	Joint Working Group
MARPs	Most At Risk Populations
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP-IV	National AIDS Control Programme, Phase IV (2013-2017)
NREGA	National Rural Employment Guarantee Act
NSS	National Service Scheme
NYKS	Nehru Yuva Kendra Sangathan
PDs	Project Directors
PSUs	Public Sector Undertakings
PLHIV	People Living with HIV
QPR	Quarterly Progress Report
RSBY	Rashtriya Swasthya Bima Yojana
SACS	State AIDS Control Society
SIRD	State Institute of Rural Development

STI	Sexually Transmitted Infection
TG	Transgender
TIs	Targeted Interventions
UNDAF	United Nations Development Action Framework
UNDP	United Nations Development Programme

1. Background

1.1 Project Synopsis

The Project “Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People” aims to build capacities of people affected by HIV for increased demand and access to rights and entitlements. It also seeks to facilitate community action for addressing laws that impede effective HIV response. More specifically, the Project provides technical assistance to NACO to reach out to MARPs with HIV/AIDS services; to integrate HIV related stigma framework in the NACP-IV; to foster inter-ministerial collaboration with non-health ministries on HIV risk reduction, addressing stigma and mitigating HIV impact; and to support civil society advocacy on Sec 377 IPC.

It is a four-year Project signed in September 2013 and concludes in December 2017. The Project was implemented by the National AIDS Control Organization (NACO) under the Ministry of Health and Family Welfare and directly supports National AIDS Control Programme (NACP-IV) under which mainstreaming and social protection are important areas of intervention to mitigate the impact of HIV.

The Project is aligned with the UNDP Strategic Plan (2014-2017) Outcome “Countries have strengthened institutions to progressively deliver universal access to basic services”, the UNDAF / CPAP (2013-2017) Outcome “Government and civil society institutions are responsive and accountable for improving women’s position, advancing their social, political, economic rights and preventing gender discrimination” and the UNDP Country Programme Outputs “HIV/AIDS affected populations experience less stigmatization and have improved access to entitlements and services” and “Women’s access to public services and programmes is expanded”.

Given the strong links between HIV and development, the response to HIV in India has expanded beyond the health sector. In a multi-sectoral approach to HIV response, NACO has assigned high priority to *mainstreaming*⁴ of HIV/AIDS

⁴ Mainstreaming addresses both the direct and indirect aspects of HIV and AIDS within the context of the normal functions of an organization, sector, institution or community. It is essentially a process whereby a sector analyses how HIV and AIDS can impact it now and in the future, and considers how sectoral policies,

activities with all key ministries and departments of central and state governments. The UNDP Project essentially supports NACO's mainstreaming efforts with the following key strategies:

1. Creation of enabling environment where the legal, policy and living environments are conducive for the PLHIV and HRG groups to access services.
2. Reduction/ elimination of stigma and discrimination faced by PLHIV and HRG at family, community and services level.
3. Provision of appropriate social protection schemes, by largely modifying existing schemes to make them more PLHIV and HRG friendly.
4. Expansion of HIV/AIDS services by fostering partnerships with other ministries, industry and corporate. There is vast health infrastructure and resources available with other ministries, which can be utilized to contribute to NACP-IV. [*Mid-Term Appraisal of National AIDS Control Programme Phase IV – NACP IV, NACO, August 2016*]

The specific outputs that address the above strategies are as follows:

Output 1: UNDP provides technical assistance and supports the development of MSM, TG implementation guidelines to enable DAC⁵ to cover 30% of the estimated most at risk population with HIV and AIDS services.

Output 2: UNDP provides technical assistance to DAC to integrate HIV related stigma framework in NACP-IV.

Output 3: UNDP provides technical assistance to DAC to foster inter-ministerial collaboration with non-health ministries on HIV risk reduction, addressing stigma and mitigating HIV impact.

Output 4: UNDP provides technical assistance to DAC to reach out to 600,000 PLHIV and populations most at risk to HIV (MARPs) accessing social protection schemes.

Output 5: UNDP provides technical support and evidence for ongoing civil society advocacy on Sec 377 IPC and access to medicines.

decisions and actions might influence the longer-term development of the epidemic and the sector.
[UNAIDS]

⁵ Department of AIDS Control (DAC) is a Department under the Ministry of Health and Family Welfare and the National AIDS Control Society (NACO) works under it.

The total budget allocated for the Project was USD 2.37 million of which USD 1.87 million was out of UNDP’s core resources and the rest was funded by AUSAID. The year-wise Project budget and expenditure was as follows:

Budget/Expenditure	2013	2014	2015	2016	2017	Total
Budget (UNDP core)	747,625	420,000	305,387	200,000	200,000	1,873,012
Budget (donor)	294,000	99,929	-	-		493,929
Budget Total	1,041,625	519,929	305,387	200,000	200,000	2,366,941
Expenditure	926,230	519,929	342,702	198,830	N/A	1,987,691

1.2 Purpose of Evaluation

This terminal evaluation has been commissioned by UNDP with a view to assess the contribution made by the Project to mainstreaming activities comprising creation of enabling environment, stigma reduction, social protection and partnerships with non-health ministries. The evaluation particularly makes an assessment of the achievements of DAPCU-led “single window” model of social protection and the role of the different stakeholders and their contribution towards the single window model. It provides recommendations and way forward.

The evaluation focuses on the following:

- Assess the contribution made by the Project to mainstreaming activities comprising creation of enabling environment, stigma reduction, social protection and partnerships with non-health ministries.
- Assess achievements under the DAPCU led single window model for social protection till date.
- Assess the role of the different stakeholders and their contribution towards the single window model.
- Identify best practices and strengths from the states/ Districts.
- Provide recommendations for improving uptake of social protection.

1.3 Primary audience of evaluation

This evaluation report is expected to be used by UNDP in designing any future interventions in this area. The report will also be of use to NACO and SACS for whom mainstreaming is an important area of focus under NACP-IV. The implementing agencies like DAPCU can, based on the feedback on “single

window”, work towards improving the effectiveness of the delivery of social protection services. The report may also be fruitfully used by the line ministries for possible modifications in the schemes to make these more HIV-sensitive. Civil society and “help desks” can benefit from the report in their work with communities on stigma reduction and social protection.

As this is the terminal evaluation report, no course corrections are possible and the findings can only be taken into account while formulating new interventions.

1.4 Structure of the Report

The Evaluation Report is divided into 5 sections. Section 1 provides the background information comprising the synopsis of the Project, the purpose of evaluation and the likely users of the findings. Section 2 details the evaluation process, scope and criteria. Findings of the evaluation, around the pre-defined criteria (relevance, effectiveness, efficiency, sustainability, impact, value addition and gender sensitivity) can be seen in Section 3, which is the core of this report. Section 4 summarizes the overall assessment and provides conclusions. Recommendations and way forward are in Section 5. Good practices and strengths from states are subsumed within the main report but are also listed in an Annexure-4. There are 4 annexures to this report.

2. Description of Evaluation

2.1 Evaluation Process

The evaluation process followed the UNDP guidelines on evaluation and used a mixed method of obtaining information. It used secondary data from Project documents, mission reports, progress reports and other studies, and supplemented this with primary data collected through interviews with a wide range of stakeholders representing NACO, SACS, DAPCU, government officials, networks of positive people, civil society and infected and affected people themselves. This method afforded triangulation of data for validity and the participatory approaches provided direct perspective from the ground. Due care was taken to keep the identity of the positive persons confidential.

A meeting was held with UNDP on 5 September 2017 to reach a common understanding on the scope and methodology of evaluation. The states / districts to be covered for detailed study were also identified. An inception report was submitted to UNDP on 8 September 2017 detailing the methodology, scope, evaluation questions and criteria of evaluation. Another meeting was held with UNDP on 24 October 2017 to provide verbal feedback on field visits. Throughout the evaluation process, UNDP was in constant touch through emails and telephone.

The desk review was followed by the data collection phase from various field visits. The consultant visited Rajasthan (Jaipur), Karnataka (Bangalore Urban), Gujarat (Mehsana) and Manipur (Imphal East) to conduct interviews with key stakeholders. A visit to Sikar though planned could not materialize due to a shut down of city following farmers' agitation. However, telephonic interviews were conducted with key people in Sikar. As the consultant could not visit the critical mass of "control" districts, reliance was placed more on "before" and "after" approach to draw conclusions about the value addition of DAPCU-led model.

A total of 40 interviews were conducted in four states a list of which can be seen in Annex-3.

2.2 Evaluation Scope

This evaluation covers the implementation phase from Sept 2013 to September 2017 of the Project "Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People". This is the terminal evaluation as the Project ends its implementation in December 2017. The findings will thus be more useful for the future activities in the same area rather than for course corrections. The geographical coverage of the "single window" is 189 districts but for evaluation purpose only 5 districts were selected due to time and resource constraints.

2.3 Evaluation Criteria

The standard DAC evaluation criteria as follows were used:

(1) Relevance: to assess the relevance of the Project to national priorities and its alignment with UNDAF and Country Programme outcomes / outputs. It also comments on the appropriateness of the Project design.

(2) Effectiveness: to evaluate how successful has the Project been in achieving the outputs that contribute to the overall outcome.

(3) Efficiency: examines the use of resources, financial and human, for achieving the results. It further probes if parallel structures were created to achieve the results or if human resources were embedded in implementing partners.

(4) Impact: becomes available only after long term implementation but it was still possible to provide pointers towards impact such as measured through increased number of benefits being accessed.

(5) Sustainability: is indicated by the action taken by government to scale up the model out of their own resources as also organizational sustainability of networks to continue with the activities after closure of the Project.

In addition, UNDP also asked the evaluator to assess the initiative around

(6) Value addition: of the overall Project as well as “single window” measured against “control” districts to see if “single window” model has contributed better results than previous ways of accessing social protection.

(7) Gender (sensitivity): to specifically focus on if the Project addresses the different needs of women, transgender and children.

2.4 Methodology

The evaluation study used both quantitative (secondary) and qualitative (primary) data. The quantitative data was gathered through Project documents (including results framework), quarterly and annual progress reports, minutes of the meetings, reports of NACO, independent research studies etc which was supplemented by the qualitative data collected during various semi-structured interviews with key stakeholders in four states.

A number of meetings / interviews were held with pre-identified respondents comprising government representatives (NACO, SACS, and DAPCU), networks of positive persons and civil society, besides the relevant UNDP Project staff implementing the initiative. For the purpose of interviews, questions were prepared in advance, supplemented by additional questions in the field.

The methodology selected is what is used in standard evaluations as it affords triangulation of data which enables both validation and collection of different perspectives. Stakeholders engaged during the interview process together represent all key parties to the implementation of the Project.

2.5 Limitations

The evaluation study allocated 23 working days which necessarily restricted the geographical coverage and the number of persons that could be interviewed. To overcome this, the sample of states was made as representative as possible. But further work in low prevalence states would be useful to test the hypothesis as to how an early intervention on social protection front can contain the spread of HIV infection and mitigate the impact of HIV.

Out of 189 districts where the “single window” model of the Project is under implementation, only four were covered plus one control district. This limits the sample size but was dictated by time and resource constraints. Selection of districts was however made purposive so that the findings are representative and reliable.

2.6 Ethical considerations

In any evaluation, the identity of informants must be guarded. This was truer in the present case given the sensitive nature of this evaluation study and the stigmatized and discriminated against population groups involved during the evaluation process. Informants were assured at the beginning of the process that their identity would not be disclosed and written consent was obtained from infected / affected informants. The written consent forms were later handed over to UNDP.

3. Findings

This section presents findings of the evaluation around DAC criteria.

3.1 Relevance

The Project is strategically very important and relevant as it directly supports mainstreaming strategies and activities under NACO's National AIDS Control Programme-IV. The Project contributes to the enabling legal, policy and living environment to make it conducive for the PLHIV and HRGs to access services. Strong advocacy by UNDP and civil society has led to the Supreme Court recognizing transgenders as the "third sex". It is remarkable that the Supreme Court in their judgement have cited and acknowledged UNDP's technical inputs on the subject. Furthering its work on TG and MSM, UNDP helped NACO in preparing Operational Guidelines for Implementing HIV Target Interventions among Hijras and Transgender People and Operational Guidelines for Implementing HIV Target Interventions for Men who have Sex with Men (MSM). UNDP's contribution and technical support in the formulation of these Guidelines was duly recognized and acknowledged.

UNDP also shared with NACO scanned laws that impede or enable HIV response. The report on such laws was presented at a workshop in December 2016 and attended, among others, by Project Directors of State AIDS Control Societies and National and State Legal Aid Services Authorities. This UNDP input has been a major contribution in the drafting of the HIV/AIDS (Prevention and Control) Bill which is now an Act 16 of 2017.

Stigma is a major barrier to infected and affected communities accessing social protection services and living a life of dignity. Under the Project, UNDP worked with ICRW to analyze the root causes of stigma (lack of awareness, social judgement, fear of infection) and adapt the global stigma reduction framework to Indian context. In particular, note must be made of the inclusion of 'intersecting stigmas' (occupation and caste) given the social stratification in India and also focus on family, rather than individual, as a target group, while working on the

stigma reduction framework in India. UNDP provided technical support to NACO to integrate stigma reduction framework under NACP IV (2012-2017).

UNDP also assisted in formulation of the “Guidelines for Prevention and Management of Stigma and Discrimination associated with HIV/AIDS” to facilitate implementation of the HIV/AIDS (Prevention and Control) Act 2017. These Guidelines once approved and adopted will be a major contribution under this project to the mainstreaming efforts.

The UNDP-supported National Survey on HIV-related Stigma and Discrimination in urban India (2014)⁶, covering 18 states, is a significant knowledge product in understanding the various types of stigma. The survey showed that HIV-related stigma persists and, more importantly, PLHIV continue to face stigma and discrimination, mostly covert, within health care settings. This was also confirmed by a number of HIV positive respondents this consultant interviewed who alleged that they were refused treatment under one pretext or another.

The Project design is holistic in approach and takes into account concerns around prevention, impact mitigation and creating enabling environment. It comprehensively addresses mainstreaming and stigma by engaging non-health ministries and signing MOUs with them for HIV risk reduction, addressing stigma and mitigating HIV impact. This has been a major initiative to sensitize the Ministries and encourage them to be more inclusive in providing services to infected and affected communities.

At the central level, a Joint Working Group, representing signatories to the MOUs, is constituted that meets regularly to develop a plan of action and monitor progress. At the state level too, MOUs are implemented by the state level Joint Working Groups comprising representatives from various government departments and chaired by PD-SACS. Such meetings are helpful in modifying schemes of relevant departments to make them HIV sensitive. Action plan for each ministry typically includes capacity building of staff on HIV/AIDS within the ministry and of institutions affiliated with the ministry; implementation of awareness programme; and review of schemes and modifications to make them HIV sensitive by changing, if needed, eligibility criteria.

A key mainstreaming strategy is the provision of appropriate social protection schemes, by largely modifying existing schemes to make them more PLHIV and HRG friendly. Under NACP-IV, social protection appears as a priority area as a means to mitigate the impact of HIV on infected and affected persons. The Project is strategically aligned to the NACO’s National AIDS Control Programme-IV the strategy document of which aims at “Ensuring social protection schemes for people

⁶ Getting to Zero? A National survey on the HIV-related Stigma and Discrimination in Urban India, UNDP, 2014

infected and affected with HIV/AIDS through mainstreaming of HIV/AIDS with other ministries". The activities under this Project also directly contribute to the state level policies on social protection and HIV/AIDS strategies.

The "single window" social protection interventions are well aligned with the UNDP Strategic Plan (2014-2017), India UNDAF (2013-2017) and Country Programme Outcome 4 that reads: "Vulnerable and marginalized populations have equitable access to and use quality basic services in selected states (i.e. health, education, sanitation, HIV and AIDS, safe drinking water)". The "single window" model is also in harmony with the operationalization of provisions on social welfare under recently enacted HIV/AIDS (Prevention and Control) Act 2017 (Chapter VII, Section 15).

The overall Project design is appropriate as it addresses exclusion by focusing on some of the most vulnerable groups namely HIV positive persons, HIV affected children and MARPs and also has appropriate geographical focus as it concentrates its activities in high prevalence districts. The Project thus contributes strongly to inclusiveness so that people with HIV/AIDS could live with dignity and without stigma. It also demonstrates scalable social protection models which could potentially become the "best practice".

The Project builds on past experience of UNDP's interventions in this area which received very positive review in the India Assessment of Development Results (ADR) Report 2012. UNDP is well positioned, trusted and valued by government for its thought leadership, regional / international experience and innovative approaches. Operational flexibility, civil society partnerships and capacity building (rather than capacity substitution) are other strengths of UNDP.

3.2 Effectiveness

Based on the desk review, interviews with a wide range of partners and field visits, it is our assessment that the Project has made significant contribution to the achievement of all the outputs and to overall outcome. A key instrument of mainstreaming has been the signing of MOUs between NACO and non-health ministries / departments with technical assistance from UNDP. This was preceded by the first ever National Mainstreaming Conference in 2011 organized by NACO in partnership with UNDP highlighting the need for non-health ministries to engage in addressing the epidemic.

So far, 15 such MOUs have been signed with as many Ministries / Departments listed at Annexure 5. A review of status on roll out of these MOUs at national and state level done in August 2017 shows some progress. Besides action on operational front like constituting Joint Working Group, designating nodal officers and preparing action plans, ground actions have also been taken by some states.

To cite a few examples, HIV is incorporated in the SIRD training programme in 5 states; messages on HIV/AIDS published in Common Service Centres (set up under e-governance programme) in Himachal Pradesh; free SMS sent by private telecom companies in Punjab and Mumbai; BSNL officials trained in Andhra Pradesh and Telangana; an ICTC started by BEST Mumbai; hoardings near toll gates installed in Tamilnadu; training for medical and paramedics conducted by Tamilnadu SACS; training for port workers conducted at 7 ports and FITC set up at Haldia; all coal PSUs have set up HIV and STI services in central hospitals; ICTCs are functional in many coal field PSUs; HIV/AIDS awareness programme conducted for NSS and NYKS; training conducted at many sports universities / institutions; and hoardings installed at petrol pumps in Odisha among others.

Gujarat recently reported setting up of F-ICTC in 23 out of 26 district jails and initiating sensitization and prevention programme for Gujarat State Road Transport Corporation staff in all their 125 depots as a follow up to MOUs reviewed in JWG meetings which needs to be captured.

State-wise progress of the implementation of MOUs is however uneven and sporadic. Even though nodal officers have been designated and JWGs set up, not all states have reported concrete actions on the ground. Mid-Term Review of NACP-IV confirm this and cites shortage of human and financial resources for mainstreaming as a reason besides inadequate communication efforts to generate awareness about mainstreaming notably social protection schemes.

Not enough time has lapsed since the signing of MOUs and it is expected that with further push from NACO and advocacy from civil society, the process of operationalization of MOUs will gather momentum. It is important that state-specific reports on the progress under MOUs are prepared and disseminated.

One of the most effective contributions made by UNDP has been advocacy to get transgender recognized as “third sex”. In a landmark judgement, the Supreme Court not only recognized TG as third sex but also issued directions to the central and state governments to take steps for the welfare of TG community. It was extraordinary for the Supreme Court to cite technical studies conducted by UNDP in their judgement. In continuation of its work on TG, recognized as High Risk Group by NACO under NACP-IV, UNDP worked closely with NACO and provided technical support for the issue of ‘Operational Guidelines for Implementing HIV Target Interventions among Hijras and Transgender People’. The guidelines provide information to CBOs/NGOs and the TI implementation staff as well as to NACO and SACS officials. Similar guidelines were issued by NACO for MSM with the technical support from UNDP. In both cases, UNDP’s contribution was recognized and acknowledged.

Much before the Supreme Court judgement, UNDP commissioned a study of the Tamilnadu Transgender Welfare Board to develop practical models of social

protection programmes for transgender people in India. UNDP also continued to provide inputs and technical support as well as advocate along with civil society in the drafting of the Transgender Bill in accordance with the spirit and letter of the Supreme Court judgement. So far following states have set up TG Welfare Boards: Rajasthan, Maharashtra, Chhattisgarh, Tamilnadu, Manipur and West Bengal. Besides, Kerala has a TG Policy in place and Odisha a draft policy on TG. Kerala has also set up a TG Justice Board to monitor and oversee the implementation of TG Policy, ensure convergence of existing schemes across departments for a more targeted approach towards welfare of TG community, among others.

The study of TG Welfare Board in Tamilnadu reported a screening process to screen self-identified TG to certify them as *aravani* (transgender). The screening involves presence of psychological, medical and TG community representative and has been perceived as humiliating apart from the fact that ambiguity about who is a TG has led to tensions. During the fieldwork in Karnataka, this consultant was informed that many TG people did not come back to claim benefits to avoid screening procedure which they find demeaning. All other states which have set up TG Welfare Boards or have TG policies in place similarly provide for elaborate screening process. Further advocacy may be needed to ensure that this screening respects the rights of TG people to privacy and dignity or altogether dropped and self-identification accepted as valid proof of identity for providing social protection benefits.

A significant study by UNDP-NACO on the “Uptake of Social Protection Schemes by Transgender Population in India” (2014) lists different social protection schemes that benefit transgender population (either directly or through general schemes), assesses current utilization pattern availed by them and the barriers for accessing the schemes. The study also identifies priority schemes that would need to be modified to benefit transgender population. Most of the schemes benefiting TG relate to identity documents but housing and employment stand out as other priorities. It is pertinent to note that many states have exclusive housing schemes for the third gender (Bihar, Chhattisgarh and Rajasthan). Stigma and discrimination, lack of proof of residence and other identity documents and lack of awareness are the major barriers to accessing social protection benefits by transgender population.

The Project also provided a compendium of laws that impede or enable HIV response which was used for the enactment of HIV/AIDS Act 2017 of which Chapter VII and Section 15 makes provisions for welfare of HIV affected and infected persons.

UNDP was equally effective in addressing the issue of stigma and discrimination. The setting up of the Technical Resource Group (in October 2014) by NACO with UNDP’s efforts was a major initiative for providing necessary guidance to develop and implement HIV stigma framework in NACP to ensure zero stigma in all

settings. The TRG is a platform that provides voice to representatives of sexual minorities and PLHIV who are members on this Group.

The UNDP-supported National Survey on HIV-related Stigma and Discrimination in urban India (2014), cited above, is perhaps the first such comprehensive survey, covering 18 states, trying to understand the sources and types of stigma, both from the perspectives of the stigmatized and the perpetrators, and makes recommendations on addressing misconceptions, trainings, campaigns, and sensitization involving PLHIV. The persistence of HIV-related stigma acts as a major barrier in accessing social protection services. The fieldwork in four states by this consultant shows that stigma varies from state to state and depends on the prevalence and location. Karnataka (Bangalore Urban) reported less cases of stigma than Rajasthan.

Even when the HIV positive persons take the courage to come out overcoming their fear, they face discrimination by the medical profession in the form of refusing to perform surgeries including dental treatment (giving one excuse or another), bad behavior by ART counselor and nurses at blood collection centres, demand for money for carrying out CD4 count in blood among others. Many states (like Gujarat) reported that they are sensitizing medical and para-medical staff on this issue and have set up grievance redressal mechanism to register cases of discrimination. The National Survey cited above, also confirms that PLHIV continue to face stigma and discrimination, mostly covert, within health care settings.

Fear of breach of confidentiality has not completely disappeared and was one of the reasons for target groups not accessing certain social protection services. It was observed that the schemes that offered highest confidentiality were the most popular schemes (Palanhar and AAY in urban areas in Rajasthan, Jatan and Tabibi Sahay in Gujarat for example) while the least popular schemes were the more “open” ones like NREGA which had no takers.

The PLHIV respondents were also averse to any schemes that required certification by a *sarpanch*. They would rather forgo the benefit than run the risk of their status being disclosed to the whole village. As mentioned above, stigma did not appear to be much of concern in Bangalore Urban and people are coming out very openly. In Manipur as well, stigma is not a major factor as many families are affected by the IDU-related HIV. No discrimination against children with HIV positive status or HIV positive parents was reported in Manipur.

Another significant report that helps in understanding stigma is the report on “Global HIV stigma reduction framework adapted to and implemented in five settings in India” namely: educational setting, multiple layers of stigma faced by rural FSW living with HIV, to combat negative attitudes towards PLHIV through engagement of local governance systems (panchayats), to capture stigma in

health settings and among MSM, and stigma at workplaces. This report was prepared by ICRW and UNDP.

An important work-in-progress is the Guidelines for Prevention and Management of Stigma and Discrimination Associated with HIV/AIDS. The Guidelines have been drafted with UNDP's technical assistance and are being discussed for adoption. Once approved and adopted these will make direct and significant contribution to the implementation of relevant provisions of HIV/AIDS (Prevention and Control) Act 2017.

The social protection aims at reducing vulnerabilities and to mitigate the impact of HIV. Social protection includes access to rights and entitlements including health, nutrition, shelter, legal aid, transport support, pension etc. The DAPCU-led "Single Window" model of social protection for People Living with HIV/AIDS (PLHIV), Children Affected by HIV/AIDS (CABA) and Most-at-Risk Populations (MARPs) is one of the outputs under the Project. The Project has been able to reach out to cumulatively increasing number of infected and affected persons reaching 1,000,000 *benefits* in 2016.

The Project directly influenced the guidelines on HIV-sensitive social protection delivery. UNDP's technical assistance to NACO resulted in the latter issuing the *Guidance Note for the Implementation of the DAPCU-led Single Window on Social Protection for PLHIV, CABA and MARPs*. Working closely with civil society and the networks, UNDP Project led to significant modifications in various schemes, including relaxed eligibility criteria or treating PLHIV at par with BPL, making the same more HIV sensitive.

Fieldwork revealed that in Gujarat and Karnataka, all service centres (ICTC, TIs, ART Centres etc) are providing information and counseling on social protection schemes. In Rajasthan and Manipur, however, ICTC merely refers PLHIV to ART Centre who in turn refer them to CSC for information and counseling on social protection. It is eventually the CSC that helps PLHIV with filling up of applications and submission with supporting documents to relevant departments.

It is interesting that the submission of applications for various schemes for PLHIV in Gujarat (Jatan, Tabibi Sahay, Scholarships) is done directly to the relevant departments by CSC and other help desks and not through DAPCU. In Rajasthan, DAPCU has no role in Palanhar scheme which is online. In Manipur as well, with the exception of AAY, DAPCU is not the routing agency and all applications are made directly by Care and Support Centres (or Vihaan Centres)⁷ to concerned departments. In all such cases, DAPCU receives a copy of the forwarding letter

⁷ Vihaan is a national initiative establishing and managing 350 Care & Support Centres (CSCs) across India to expand access to essential services, increase treatment adherence, reduce stigma and discrimination, and improve the quality of life of people living with HIV (PLHIV).

through which CSC / help desks submit the applications. DAPCU and CSC then jointly follow up with the relevant departments.

DAPCUs are not equally effective in all states. In Gujarat, these are headed by District TB and HIV Officer (DTHO) who, as the name suggests, also has TB as his / her responsibility. The day-to-day monitoring is done by a relatively junior District Supervisor, who is of late also given additional charge of a neighbouring district. In Karnataka, DAPCU head is also Medical Officer of a PHC with DAPCU being one of the many responsibilities. In all the states visited, DAPCU was not adequately staffed or funded to perform their role. DAPCU's data systems were weak in Rajasthan but much better in other states (Gujarat and Karnataka). In Rajasthan, DAPCU does not sign the forwarding letter - it is the CMHO who does and is critical in this scheme. DAPCU DPO relies on CMHO for advocacy and support.

Even though motivating infected and affected people to apply for social protection schemes may not be a direct role of DAPCU, and it does not by itself reach out to communities, it is mandated to organize camps for awareness and demand generation for social protection schemes. DAPCU relies on help centres and PLHIV Networks for outreach who are more effective in motivating target people as part of their counseling activities. This is uniformly true across all states visited.

The single major role of DAPCU has been follow up with government departments. While advocacy by SACS led to modifications in schemes in many states to make them more HIV sensitive, follow up by DAPCU with relevant government departments led to getting expeditious approval of schemes. Most respondents recognized that follow up by DAPCU was more effective than by NGOs. In states where applications are routed through DAPCU, the rejection rate has gone down drastically. Rejections in Karnataka and Gujarat were rare. Saving in time, effort and cost was also reported from all states though any quantification is not possible. Respondents were uniform in reporting that earlier they had to run around the various departments and face discrimination, corruption and harassment. But DAPCU's interface has saved them from all this.

Though rejection rate has declined, there is huge gap in Rajasthan and Manipur between the number of people registered with ART Centres and the number that finally applies for schemes. Even smaller number finally benefits. For example, in Rajasthan, out of 13,892 PLHIV who agreed with ART / CSC only 3491 applied and 3234 benefited. Reasons are many: sometimes old patients dissuade the new ones at ART Centres against such schemes citing their own experience of delays, corruption, breach of confidentiality, and unnecessary paperwork, among others. Only a small percentage of cases come back to CSC / DAPCU with necessary documents for further processing. Complaints of excessive requirement of documents are still being reported from all states. In Manipur, applications were pending for 2-3 years with no response from the government which frustrated the

PLHIV and they became suspicious of the motive behind these applications. However, success in terms of entitlement benefits (Aadhar card, ration card, birth certificate, BPL card, etc) is much higher uniformly in all states and practically all those who apply get the benefit.

In terms of capacity building, the Project specifically engaged with key implementers and worked with staff in CSCs, TIs, DAPCU and others. It developed guidelines on increasing access to social protection by HIV affected populations; web-based portal on social protection which is an important source of information; a module on social protection that was used for training of key stakeholders; and built capacity of CBOs who have taken social protection seriously as part of their mandate. SACS was more active in Gujarat and has formed a core team of trainers that is called upon to build capacity of DAPCU and help desks. Under the prevention area, the UNDP Project developed the capacity of the project staff working for the Targeted Interventions projects that resulted in effective support to the sexual minorities.

Manipur made good use of non-conventional sources of social protection. Under the District Innovation Fund, created under the 13th Finance Commission, benefits were provided to 200 HIV positive women of which 5 received loans under MUDRA Yojana. Similarly, one time financial assistance of Rs 40,000 for HIV widows was provided to six widows under the Indian Red Cross Society's livelihoods programme. Many PLHIV also received benefit through a local philanthropist, Marup Loi Foundation and World Vision.

The roles of DAPCU, SACS and NACO are well defined in *the Guidance Note on DAPCU-led Single Window Model* issued by NACO. The DAPCU office acts as a single window for provision of social protection services to infected and affected communities. DAPCU officer collects applications from various service centres (designated as "help desks"), submits to concerned departments and follows up as necessary. The role of SACS is to issue directives to DAPCU for implementation of "single window model of social protection and also to all facilities at district level to establish social protection helpdesks. SACS also advocates for amendments in existing schemes to further make these HIV sensitive. The help desks generate demand and facilitate access to social protection by helping applicants complete their applications with required documents (Aadhar card, voter Id, BPL card).

The DAPCU-led social protection aims at creating enabling environment where PLHIV, CABA and MARPs are able to access social protection without stigma or discrimination. Its objective is also to increase the enrolment of infected and affected communities in the social protection schemes by modifying the schemes to make them more HIV sensitive.

Even though "single window" approach itself may not be innovative, as there are several examples in India of successful single window e-governance initiatives, the

approach and the processes leading up to “single window” were innovative. In particular, we must mention the campaign approach used to generate demand, which brought together target groups along with departments and community members. The filling up of applications and submission to the concerned departments took place simultaneously thus saving time and giving more confidence to field staff. These camps were not only for conventional social protection schemes but also offered help in developing business plans as part of self-employment placements. Overall, the camp approach is more effective (at least in initial phases) in aggregating demand. However, once all partners are sensitized, its repeat may not be necessary and standard procedures may just be as effective.

The overall effectiveness of the Project is rated exceptional as it aimed to mainstream HIV, worked to secure justice for sexual minorities and, through social protection schemes, strived to reduce vulnerabilities and mitigate the impact of HIV. UNDP’s work in the area of TG is particularly noteworthy as also work in support of the HIV Bill which is now an Act. Over one million benefits have been provided the infected and affected people. All these show to demonstrate strong partnership between UNDP and NACO.

3.3 Efficiency

The overall assessment is that the Project was being implemented in an efficient manner and both financial and human resources were put to most efficient use. No duplications were found. The strategy of embedding technical experts in NACO (working closely with state governments) to provide prototyping support, technical assistance in determining the feasibility of scaling up, developing the social protection portal has not only been cost-effective but also ensured national ownership and enhanced development outcomes. Being part of the system helped these experts move things quickly. Five experts housed within the Mainstreaming Unit of NACO assisted NACO throughout the process of formulation of HIV Bill – preparing notes, making presentations, holding consultations, framing rules, among others. The HIV Bill had 50 clauses making references to various guidelines. It was the UNDP experts in NACO who identified the relevant guidelines and ensured these were up-to-date and aligned with the Bill.

This practice of embedded experts, at central and state level, which were available to NACO and States AIDS Control Societies, on hand, established UNDP as a credible partner genuinely interested in national capacity building and effectively took mainstreaming and social protection agenda forward. Recognition and acknowledgement of UNDP support in most government / NACO documents confirms this.

For the budget under this Project, the achievements have been significant thanks to the national implementation and committed partnerships which avoided the

need for creating parallel structures (like a PIU) for implementation. This Project demonstrates that the strength of ideas and commitment far outweighs the budgetary allocation.

The absence of a sound Results and Resources Framework, made comparisons over time difficult and measurement of progress with any sense of precision challenging. The AWP for 2013, 2014, and 2015 had no baselines, indicators or means of verification. The targets were subsumed in the outputs. However, baselines, indicators and targets appear for the first time in AWP 2016. The Multi-Year Project Strategy Description is also not appropriately designed, as it does not have any baselines or indicators. It has targets but in the absence of indicators it is difficult to say what do these targets refer to. It would have been good to mention baselines even if these were zero. Though the Project is very sound on substance, on monitoring framework it is somewhat weak. There was no clear articulation of what would determine the success, or otherwise, of the Project.

The target of number of persons accessing HIV sensitive social protection services (part of the output formulation) kept changing in every AWP. In 2014, the target was to benefit 600,000 PLHIV, in 2015 it was 800,000 and in 2016 1,000,000 PLHIV. A better approach would have been to keep the target fixed and report achievement against these targets. However, there was a recent transition by NACO to measure progress in terms of *benefits* rather than number of *persons*. As of now, we are informed that more than 1 million benefits have been provided.

Two PSC meetings took place during the Project implementation - one in October 2015 and another in October 2016. At the time of writing this (November 2017) the third PSC meeting for 2017 was yet to take place. Delays in approval of AWPs were also reported. The QPRs are skimpy and quality of Annual Progress Reports variable (2014 much more detailed than 2015).

Finally, even though the Project was entirely funded out of UNDP core resources, it catalyzed resources in terms of the government funding of the DAPCUs. Use of MOUs as a strategy also leveraged resources in non-health Ministries to set up ICTC, ART centres etc. One of our recommendations is to quantify these resources. With reported decline in UNDP core resources, the Project must continue to catalyze parallel funding from government for future interventions in this important area. UNDP should remain engaged, as new opportunities will open up once implementation of the HIV/AIDS Act 2017 is rolled out.

3.4 Impact

The Project has positioned mainstreaming efforts to a higher level making it central to multisectoral response to HIV/AIDS. Working with NACO and other stakeholders, the Project has placed HIV/AIDS as a development challenge that

goes beyond the realm of bio-medical interventions and needs non-health interventions especially in a country like India with low prevalence and low visibility.

Signing of MOUs with non-health ministries has led to greater awareness amongst the staff, strengthening of internal health care facilities making these HIV sensitive, and modifications in social protection schemes of various ministries. It is encouraging that there was not only no resistance from ministries to change their schemes but greater understanding and readiness to modify eligibility criteria and conditions to make the schemes more inclusive of HIV. Even at the district level, government officials were inclined to be more inclusive if they were informed of the specific needs of infected and affected people. However, it must be added that it required persistent dialogue and hard work by UNDP and NACO at multiple levels to achieve this.

The mainstreaming efforts required systems to be put in place and make them robust and functional as well as issuing of formal guidelines. This has been another impact of the Project. Technical support in setting up of TG Welfare Boards and inter-ministerial Joint Working Group to monitor the MOUs and issuing of operational guidelines on TG and MSM have been significant contributions of the Project.

Another major impact has been the modifications that various state governments and line ministries carried out in their social protection schemes to make them HIV sensitive. Many schemes saw their eligibility criteria relaxed or the scheme itself extended to cover infected and affected people as vulnerable groups eligible for benefits. Relaxation of age limit for HIV widow pension, provisional BPL status conferred on HIV positive people, taking out HIV from the exclusion list of RSBY, and use of more sensitive / camouflaged language in the government communications and identity cards issued to beneficiaries are good examples of how general social protection schemes can be made HIV sensitive. This offers huge potential for invigorating general (non-HIV) social protection schemes and making them sensitive to specific needs of other groups as well (such as persons with disabilities).

However, in Manipur no scheme was modified to make it HIV sensitive or any schemes designed exclusively for PLHIV (except travel concession). All the general schemes were equally applicable to PLHIV and they were supposed to apply for the same along with general population. In a forthcoming meeting with the various line departments, MACS / DAPCU were planning to make proposals to make some schemes HIV sensitive such as free bus passes, full coverage of PLHIV under AAY, among others.

The overall uptake improved significantly in last three years and so did the number of benefits. As of now, more than 1 million *benefits* have been availed by people infected or affected by HIV/AIDS. Between 2012 and 2017, the number of AAY

beneficiaries in Karnataka, for example, went up from 15063 to 34786. There is huge demand for making identity documents (Aadhar card, ration card, BPL card etc), which enables the applicants to apply for other social benefits and reduce their vulnerability. In fact, number of applications for this service is nearly at the same level as the actual social protection schemes.

The most significant impact of the mainstreaming and anti-stigma activities under the Project has been, as noted earlier, recognition of transgenders as a third sex by the Supreme Court paving the way for further action for the welfare of this community including setting up of welfare boards where UNDP is already actively supporting the government including help in drafting TG policy at state level. It is a recognition of UNDP's technical assistance to the government that in Rajasthan UNDP is a member on the TG Welfare Board. The passage of HIV/AIDS (Prevention and Control) Act, 2017 drafting of which was also supported by UNDP through NACO, creates enabling legal and social environment to fight stigma, provide social protection without discrimination and affords PLHIV, CABA and MARPs a life of dignity.

The "single window" initiative on social protection was showcased at the UNAIDS Programme Coordination Board (PCB) meeting in Geneva (2014) which encouraged Cambodia, Myanmar, Thailand and Vietnam to have south-to-south exchange with India on this issue.

3.5 Sustainability

The sustainability of the mainstreaming initiatives under the Project can be gauged from the fact that as many as 15 non-health ministries are on board to collaborate with NACO on mainstreaming activities. The "single window" model of social protection that was prototyped by UNDP in 2013 was scaled up and operationalized in 100 priority districts in 2014 and later scaled up to all 189 districts under DAPCU. That this scaling up was funded by the government out of their own resources and without additional staffing shows the effectiveness of the model as well as strong national commitment to providing HIV sensitive social protection.

The Project has also built adequate capacities with facilitators at the help desks and staff at DAPCUs to carry on the activities on their own without any external support. However, the staff turnover, new interventions and need to advocate and stay engaged with partners and communities necessitate continuous capacity building of service providers. Also the success in future of mainstreaming activities requires active involvement of non-health ministries in capacity building. That this needs to come about without additional financial or human resources makes it challenging but should trigger more creative and cost-effective capacity building strategies.

The single most important factor that contributed to the sustainability of the “single window” model was the strong partnerships the Project forged. The convergence of networks of positive persons, sensitive officials in line departments and DAPCU staff all worked towards making single window model an effective way of delivering social protection to infected and affected people. Each partner within the government (NACO, SACS and DAPCU) had clearly defined roles as documented in *the Guidance Note*.

The Project also identified champions of social protection within the government not least NACO whose positive attitude towards social protection, willingness to issue directions to (and coordination with) SACS and close work with line departments, that modified the schemes to address the specific needs of key populations, led to the improved uptake and scaling up of the single window model. DAPCU support was instrumental in training counselors on social protection to reach hard-to-reach communities.

Interviews with line departments were clear that they value their partnership with the networks of positive people. This not only potentially expands the coverage, it also reduces time, effort and costs in identifying and reaching out to larger number of similarly placed people. This approach can be fruitfully utilized for providing benefits to other vulnerable groups such as PWDs.

The Project acquits itself very well in knowledge management, a key contributor to sustainability. A number of products and documents have been prepared to support NACO in their mainstreaming efforts. Mapping and Size Estimation of Hijras and other Transgender Populations in 17 States of India, Operational Guidelines on TG and MSM, the National Survey on Stigma, the Compendium on Social Protection Schemes, the Guidance Note on the DAPCU-led Single Window Model, the Study on TG Welfare Board Models, among others, are first-of-its-kind knowledge products of great practical import.

Social protection portal that was a product of this Project is up and running. It is a useful resource providing state-wise and gender-wise (including separately for transgender) information on various social protection schemes available to key populations. The portal is already transferred to NACO who keep it updated.

A key factor that will contribute to sustainability is the need to provide social protection as mandated within the recent HIV/AIDS (Prevention and Control) Act 2017. Governments at the centre and states will need to put a more robust social protection system in place and formulate an HIV sensitive social protection policy.

3.6 Value addition

The Project added value to the functioning of NACO by providing technical support

to their mainstreaming activities and thus enabling realization of the relevant goals under NACP-IV. UNDP has been in the forefront in mapping TG population, building capacities of partners from national to district level, piloting initiatives, providing technical papers, advocating, presenting evidence and so on. These activities encompassing legal, social, policy dimensions strengthened NACO's hands in effectively mainstreaming HIV and engaging non-health players.

The single window model of social protection brought together various partners for a common cause. The partnership of government, networks and civil society was exceptional. DAPCU's interface resulted in lower rejection rate for applications as DAPCU pre-screens all applications against criteria and supporting documents required. The applicants do not have to run around and chase the departments. This saves time which they can use for care and work.

Another significant value addition of the model is the advocacy role played by DAPCU and networks. This led to many changes in the schemes at district level although modifications in schemes can only happen at the state level. In Dahod (Gujarat) for example, we were informed that following DAPCU advocacy, the district collector relaxed the income criteria for HIV positive tribal population to access benefits. Similarly, in Mehsana the district collector included all positive persons in BPL category to grant coverage under AAY. In Imphal East, the District Supply Officer covered all HIV positive persons under AAY regardless of their BPL status. Yet, these are exceptions rather than rules and very specific to the individual officials. Most changes require state level intervention.

Sending applications through DAPCU also means that the PLHIV can seek social protection with relative confidentiality although complete confidentiality appears difficult to achieve. The applicants see if the benefits outweigh the cost in terms of breach of confidentiality. With more and more schemes being launched, the stigma is breaking down as the Karnataka experience shows and balance tilting towards coming out in the open to claim the benefits. In Manipur, stigma is not the issue but the lack of HIV-sensitive policy and programmes is. The strength of belonging to a network enables members to raise their voice and be more assertive to claim their rights. There are also complaint mechanisms to take action against people who discriminate against PLHIV.

The "single window" model has made government officials more sensitive and flexible to the needs of the infected and affected people. From a pure practical point of view, since all applications come from a single point where information, needs and priorities of infected and affected people are available, for the government this lowers the transaction cost and expands the coverage.

With the 'test and treat' policy, all persons tested HIV positive will be put on ARV treatment regardless of CD4 count. This will also increase the numbers wanting to access social protection. With the SW model in place, it should be possible to deal

with enhanced numbers.

3.7 Gender equality

The Project is rated highly for its gender sensitivity, defined broadly to include transgender and children, as it promoted availability in a stigma-free environment of social protection services for women living with HIV, HIV widow and women as guardians of children affected by HIV. Besides, positive children themselves, children of positive parent(s), transgenders, FSW were also specifically addressed by various social protection schemes.

By and large, social protection schemes are biased in favour of women with few schemes that target MARPs, even though transgender have lately started to benefit from specially designed schemes. Low access to social protection services by MARPs is for various reasons: unwillingness to come out openly; high mobility leading to lack of residence proof and other identity documents; and relatively better off employment / economic status hence no pressing need for social protection. However, there is need to design HIV sensitive schemes for MARPs, as distinct from HIV specific, and create awareness so that MARPs can access alternative income generation schemes.

Although DAPCU does not keep gender-disaggregated data, visibly it did not appear that women were in any way hesitant to come forward to avail of social benefits. On the contrary, perhaps women overcome and handle stigma much better than men. In all the network meetings this consultant attended, women far outnumbered men and were more vocal in expressing themselves on social protection issues. This was true across all states (somewhat less in Rajasthan though). In Gujarat, during the dissemination of HIV issues through *nukkad nataks* (street theatre), young women in rural areas were more active in asking questions.

With the recognition of transgender as third sex, there is hope that they will be able to lead a life of dignity. Many states have exclusive schemes for them. For example, Karnataka has the Maitri scheme under which DAPCU receives the list of TGs from Revenue Department. DAPCU then verifies the TG status of the persons in the list. For this purpose, the TGs are subjected to biological and psychological tests in a hospital to verify if they are indeed TGs. This is found to be humiliating by many TGs who refuse to go to the hospital and prefer to forgo the benefit.

Notwithstanding many schemes that benefit CABA (Palanhar in Rajasthan; and Palak Mata Pita in Gujarat), most states (except Manipur) reported that children in school face discrimination with parents of general children threatening to withdraw their wards from school. Strong district administration that protected the rights of CABA (Gujarat), change in requirements from school principal issuing a certificate

to online certification (Shala Darpan in Rajasthan), dropping of question on HIV status from school form, direct transfer of benefits to children and not disclosing the identity of children to banks (Karnataka, Gujarat) have gone a long way in protecting children against discrimination.

In Manipur, the Pediatric Centre of Excellence was receiving nutrition packages from the Department of Social Welfare under the Double Nutrition to Children scheme. But the Department discontinued this in 2014, on the ground that children are already receiving benefits under ICDS. This was raised with the Department who were more than willing to resume supplies of nutrition packages to the Centre. This again proves that advocacy is a continuous process and the concerned partners must keep the pressure on.

4. Conclusions

Based on the findings of the evaluation, following conclusions can be drawn.

1. The Project has performed extremely well in highlighting the importance of mainstreaming including creation of enabling environment, combating stigma and provision of HIV sensitive social protection schemes for the PLHIV, CABA and MARPs. The Project contributed significantly to reducing their vulnerability, mainstreaming them with general population and protecting and promoting their right to live without stigma and with dignity.
2. The Project is highly relevant in terms of the National AIDS Control Programme, UNDAF and CPAP. It supports operationalization of HIV/AIDS (Prevention and Control) Act 2017 and rights of sexual minorities, especially transgender. The Project covered a vast array of activities like mapping TG population, piloting initiatives, preparing technical documents and compendium, drafting operational guidelines, building capacities, developing portal thus being of direct support to NACO in the implementation of NACP-IV.
3. The overall effectiveness of the Project is extremely good. At the national level, signing of 15 MOUs was a key achievement. Sharing of scanned laws that impede or enable HIV response was instrumental in drafting of HIV Bill, which was later enacted as an Act.
4. Strong advocacy led to the Supreme Court recognizing transgenders as the “third sex” which paved the way for taking further action for the welfare of this most discriminated against high-risk group.
5. Notwithstanding some state-level differences, the Project helped improve the uptake of social protection schemes, reduced stigma and motivated line departments to provide HIV-sensitive social protection schemes and modify

them if needed.

6. The Project is a good example of the strong partnership between DAPCU, networks and line departments in delivering results. It is our conclusion that DAPCU and network together are a more effective force than either of them alone.
7. The efficiency of the Project remained high as it provided technical support that was embedded within national bodies (NACO) rather than creating parallel structures. This promoted national ownership, lowered the cost of activities, supplemented (rather than supplanted) capacities and enhanced development outcomes. It also positioned UNDP as a credible partner genuinely interested in capacity development.
8. The overall design of the Project is very good and simple. However absence of a Results and Resource Framework with baselines, indicators and targets, and means of verification was not helpful in the task of evaluation. The evaluation had to necessarily rely on the Project progress reports and data collected from sample states.
9. The impact of mainstreaming activities under the Project was high as evidenced by the Supreme Court judgement on transgender, signing of MOUs and follow up by non-health ministries, and improved uptake of social protection schemes. More and more people want to associate with these schemes provided the access is fast and stigma-free. The high demand for identity documents is an indication of their wanting to live like general population. Flexibility and commitment shown by state governments, sometimes at district level, to modify schemes to make them more accessible augurs well for the future of this intervention.
10. Given the role of social protection in reducing vulnerability and mitigating HIV impact, it might be worth considering this as a preventive strategy by specifically designing schemes that address vulnerability factors (poverty, migration, ignorance, gender and other social inequalities). UNDP is well placed to advocate on this issue.
11. The Project activities will continue even after UNDP withdraws. This is because of the UNDP strategy to provide embedded capacities in NACO, knowledge base built and the strong partnerships forged. The government was quick to scale up “single window” model to 189 districts in the country with their own resources. This is a solid example of sustainability. The Project document however does not have an exit strategy.
12. The Project does very well on gender equality – broadly defined to include sensitivity to women, transgender and children. The model serves these groups

very well with specific schemes for each of these categories. Women were found to be very active and vocal in the networks and their presence far outnumbered that of men. There were fewer schemes for transgender persons; but this may change once the new Act is passed.

5. Recommendations

1. Since MOUs with non-health ministries is a key instrument of mainstreaming, it is important that the Joint Working Groups meet regularly and robust monitoring system is put in place at the state level to gauge progress and to prevent disjointed response by line ministries.
2. Transgenders are the most discriminated against high-risk group and hence policies and programmes are needed, that go beyond the TG Welfare Boards, to identify meaningful alternative livelihood opportunities for them to wean them away from begging and sex work. UNDP as a champion of inclusive growth is well poised to design appropriate interventions in the next CPD (2018-2022) which would be particularly relevant in view of the impending TG Act.
3. UNDP should continue to work with civil society and advocate for self-identification by TG rather than subjecting them to biological and psychological screening before granting benefits so that, in the spirit of the Supreme Court judgement, the transgender persons are treated with dignity.
4. A basic minimum package for PLHIV, which has been recommended in the past⁸, is worthy of further consideration and UNDP should work with NACO/SACS/line ministries to operationalize this.
5. Taking the above point further, UNDP should advocate for social protection as a preventive strategy highlighting the role of social protection schemes in reducing vulnerabilities and mitigating the impact of HIV.
6. As DAPCUs are likely to remain the lynchpin of the “single window” model they need to be strengthened and empowered with more funds at their disposal for training, monitoring and outreach so that they can perform their mandate as envisaged in *the Guidance Note*.
7. With growing digitization, there is need to find online solutions to link DAPCU, networks and line departments and promote greater use of Common Service

⁸ HIV Sensitive Social Protection – A Four State Utilization Study, UNDP and Tata Institute of Social Studies, 2011

Centres. This will promote efficiency, reduce corruption, ensure confidentiality and strengthen monitoring and database in the delivery of social protection services.

8. Procedural requirements for the infected and affected people are still too heavy and need to be further simplified. While procedures are formulated at the central / state level keeping in mind possible misuse of the programmes and to target them better, SACS needs to advocate for minimizing the procedural burdens by sensitizing the line departments.
9. Many philanthropists and private sector companies are / might be willing to supplement government efforts in social protection and may not know how to go about it or what the needs are. This potential should be tapped and brought within the ambit of DAPCU.
10. It would be desirable for NACO to quantify the benefits of signing MOUs in terms of saving of resources in setting up HIV sensitive health care facilities in the ministries and their associated departments / PSUs.
11. The MOUs signed between NACO and non-health ministries are being reviewed at the state level JWG meetings and follow up action is being taken. It would be interesting to document the state level progress (as distinct from ministry level progress) in the implementation of the MOUs.
12. For the future interventions, UNDP should strengthen its results and resources framework with clearly defined baselines, indicators, targets and means of verification.

Annex 1: List of Documents Reviewed

- India, Government of (2017) – HIV/AIDS (Prevention and control) Act, 2017
- India, Government of (2014) – MOU between the Department of Defence, (Ministry of Defence) and Department of AIDS Control (DAC, later NACO) (Ministry of Health and Family Welfare), 18 February 2014.
- India, Government of (2015) – MOU between the Department of Empowerment of Persons with Disabilities (Ministry of Social Justice and Empowerment) and National AIDS Control Organization (NACO) (Ministry of Health and Family Welfare), 27 January 2015.
- India, Government of (2015) – MOU between the Department of Rural Development (Ministry of Rural Development) and National AIDS Control Organization (NACO) (Ministry of Health and Family Welfare), 10 June 2015.
- India, Government of (2016) – Minutes of the Meeting of Joint Working Group for taking forward the MOU signed between Department of Rural Development and NACO, 17 October 2016

ICRW-UNDP (2013) – A global HIV stigma reduction framework adapted and implemented in five settings in India, International Center for Research on Women and United Nations Development Programme, 2013

Kerala, Government of (2015) – State Policy for Transgenders in Kerala, Department of Social Justice, 2015

NACO (2015) – Guidance Note for the Implementation of the DAPCU-led Single Window Model for Social Protection of PLHIV, CABA and MARPs.

NACO (2013)– Mainstreaming and Partnerships – A Multi-sectoral Approach to strengthen HIV/AIDS response in India, 2013

NACO (2014) – Operational Guidelines for Implementing Targeted Interventions among Hijras and Transgender People in India, NACO, 2014

NACO (2015) – Operational Guidelines for Implementing HIV Targeted Interventions among Men who have sex with men in India, NACO, 2015

NACO (2016) – Mid-Term Appraisal of National AIDS Control Programme Phase IV, August 2016.

NIE-SRI (2014) – Technical report Mapping and Size Estimation of Hijras and other Transgender Populations in 17 States of India, A Study conducted under the aegis of NIE-ICMR, UNDP and NACO,

Odisha, Government of (2017) – Odisha Transgender Policy 2017 (Draft)

UNDP-TISS (2011) – HIV Sensitive Social Protection – A Four State Utilization Study, UNDP and Tata Institute of Social Studies, 2011

UN (2012) – United Nations Development Action Framework 2013-2017, July

UNDP (2012) – Country Programme Document for India 2013-2017, March

UNDP (2012) – Country Programme Action Plan (2013-2017)

UNDP (2012) – Assessment of Development Results (ADR) India, April

UNDP (2012) – The Case of Tamilnadu Transgender Welfare Board: Insights for Developing Practical Models of Social Protection Programmes for Transgender People in India, 2012

UNDP (2013) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Work Plan, 2013

UNDP (2013) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Report, 2013

UNDP-UNAIDS (2013) – HIV Sensitive Social Protection – A Review of Cambodia’s Social Protection Schemes for Incorporating HIV Sensitivity, 2013

UNDP (2014) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Work Plan, 2014

UNDP (2014) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Report, 2014

UNDP-NACO (2014) – Uptake of Social protection Schemes by Transgender Population in India, 2014

UNDP (2014) – Getting to Zero? A National Survey on HIV-related Stigma and Discrimination in Urban India, 2014

UNDP (2015) – Outcome Evaluation of CPAP (2013-2016)

UNDP (2015) – Results Oriented Annual Report 2014
 UNDP (2015) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Work Plan, 2015
 UNDP (2015) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Report, 2015
 UNDP (2016) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Work Plan, 2016
 UNDP (2016) – Increasing Access to HIV/AIDS Prevention and Care for Vulnerable People”, Annual Report, 2016
 UNDP (2016) – HIV Social Protection Compendium, 2016
 UNDP (2016) – Results Oriented Annual Report 2015
 UNDP (2016) – HIV and the Law in India-A Scan of Laws that Create the Framework
 UNDP (2017) – Results Oriented Annual Report 2016

Annex-2 List of People Interviewed

S No	Name	Designation
1.	Dr S S Chauhan	Programme Director, Rajasthan SACS, Jaipur
2.	Mr R. K. Soni	Assistant Director, Care Support and Treatment Division, Rajasthan SACS, Jaipur
3	Dr Anuradha Singh	DPO, DAPCU, Jaipur
4	Ms Prerna Mittal	Counsellor, ICTC, Jaipur
5	Mr Devendra Sharma	Counsellor, ART Centre, Jaipur
6	Mr Babu Lal Parmar	Incharge, Vihaan CSC Centre, Jaipur
7	Mr Bhagwan Sahay Sharma	Assistant Director, Social Welfare Department, Government of Rajasthan, Jaipur

8	Mr Purushottam (telephonic)	Counsellor, ICTC, Sikar
9	Mr Anil Kumar (telephonic)	Counsellor, CSC, Sikar
10	Mr Vikram Sharma (telephonic)	PD, CSC, Sikar
11	Mr Dusad	Rajasthan State Road Transport Corporation, Jaipur
12	Dr Asha	Incharge, DAPCU, Bangalore Urban
13	Mr Thyagaraj	President, KNP, Bangalore
14	Dr Nirmala	Senior Medical Officer, ART Centre, Bengaluru
15	Ms Narmada	Director, Women and Child Development, Government of Karnataka, Bengaluru
16	Dr Shamlal Iqbal	PD, KSACS, Bengaluru
17	Mr Srinivas Gowda	Additional PD, KSACS, Bengaluru
18	Mr Shiv Kumar	Swasti, Bengaluru
19	Mr Manubhai Vaghela	AD, Mainstreaming, GSACS, Ahmedabad
20	Mr Pratik Raval	AD, GIPA, GSACS, Ahmedabad
21	Dr Rajendra Gadhvi	Joint Director, BSD, GSACS, Ahmedabad
22	Mr Sudhir Chavla	Joint director, CST, GSACS, Ahmedabad
23	Mr Hemant Shukla (telephonic)	Joint Director, IEC, GSACS, Ahmedabad
24	Mr Chaitanya Bhatt	TI, GSACS, Ahmedabad
25	Mr Bhavesh Rana	District Supervisor, DAPCU, Mehsana
26	Dr K K Patel	District TB and HIV Officer (DTHO), Mehsana
27	Dr T K Soni	CDHO, Mehasana
28	Dr Girish Kandoi,	Medical Officer, ART Centre, Mehsana
29	Ms Asha Patel	Project Director, Vihaan Care and Support Centre, Mehsana
30	Mr B L Gadhvi	District Child Protection Officer, Department of Social Welfare, Mehsana
31	Dr N Romila Devi	DACO, DAPCU, Imphal East
32	Ms Devlin Keishing	Counsellor, ART Centre, Imphal East
33	Dr Ng. Bembem	Nutritionist, Pediatric Centre of Excellence, JNIMS, Imphal
34	Mr Kh. Naoba	Project Coordinator, CSC, Imphal
35	Mr Madan (spl?)	Programme Coordinator, CSC, Imphal
36	Ms Jacinta Lazares	Director, Social Welfare Department, Government of Manipur, Imphal
37	Ms Valentina Arambam	Project Director, Manipur AIDS Control Society (MACS), Imphal
38	Dr Th Hemlata Devi	Deputy Director (DAPCU), MACS, Imphal

39	Dr Lucy Duidang	Deputy Director (IEC and Mainstreaming), MACS, Imphal
40	Ms Elizabeth Michael	AHF (AIDS Health Foundation) New Delhi

Annex-3: Good Practices

During the fieldwork in four states, evaluation noted a number of state / district level good practices, some of which are easily replicable in other areas. Many examples of modification of schemes or flexibility of district officials came to light that helped infected and affected people.

Rajasthan relaxed the age limit fixed at 40 years for widow pension scheme to include all HIV widows regardless of their age. This helped a number of young HIV

widows. In Karnataka, all people living with HIV were treated as BPL and no additional eligibility criteria were required. Being HIV positive was enough to access social protection benefits under most schemes. In Rajasthan, under Palanhar scheme, two eligibility criteria – namely, permanent residence proof and school attendance certificate from the principal – were dropped to simplify the scheme and protect the identity of the applicants.

At the district level, flexibility used by district officials was similarly beneficial for infected and affected people. In Dahod (Gujarat), we were told, advocacy by DAPCU led to relaxation of income criteria to benefit all the positive tribal population. Likewise, a good district supply officer in Manipur covered all HIV positive persons under AAY.

Examples of tapping on private sector and philanthropists to supplement social protection efforts have also come to light. Manipur made good use of non-conventional sources of social protection. Under the District Innovation Fund, created under the 13th Finance Commission, benefits were provided to 200 HIV positive women of which 5 received loans under MUDRA Yojana. Similarly, one-time financial assistance of Rs 40,000 for HIV widows was provided to six widows under the Indian Red Cross Society's livelihoods programme. Many PLHIV also received benefit through a local philanthropist, Marup Loi Foundation and World Vision.

In Gujarat, Tabibi Sahay is an important scheme which recently got transferred from the social welfare department to the health department. Since then effectiveness of scheme has improved, confidentiality is much better (data is not shared with anyone, not even banks) and more importantly department is making good use of ASHA workers to advocate, collect information and for other reach out activities including motivation.

The Palanhar scheme in Rajasthan makes good use of mobile phones of the applicants. All the applicants are informed of the status (approved, rejected or objections) on their mobiles. This is faster, more direct and more confidential.

Organization of camps for generating demand for social protection is another good practice. These camps brought together target groups along with departments and community members. The filling up of applications and submission to the concerned departments took place simultaneously thus saving time and giving more confidence to field staff. These camps were not only for conventional social protection schemes but also offered help in developing business plans as part of self-employment placements.

Capacity building of 14 FSW in developing their own business plans, out of which 4 received loans under the Udyogini scheme in Karnataka, was a significant contribution under the Project that went beyond conventional social protection

schemes and widened the scope to cover self-employment.

Annex-4: List of MOUs signed by NACO with Non-Health Ministries

S No	Department / Ministry	Date of Signing
1.	Department of Internal Security, Ministry of Home Affairs	1 September 2017

2.	Department of Rural Development	10 June 2015
3	Department of Empowerment of Persons Living with Disabilities	27 January 2015
4	Ministry of Commerce and Industry	8 June 2015
5	Department of Electronics and Information Technology	23 July 2014
6	Department of Telecommunications	23 July 2014
7	Ministry of Rural Transport and Highways	9 June 2014
8	Ministry of Defence	18 February 2014
9	Ministry of Housing and Poverty alleviation	11 December 2013
10	Ministry of Shipping	14 February 2013
11	Ministry of Coal	9 September 2013
12	Ministry of Human Resource Development	6 August 2013
13	Ministry of Youth Affairs	29 November 2013
14	Department of Sports	29 November 2013
15	Ministry of Petroleum and Natural Gas	5 December 2013