05

PARLIAMENT OF INDIA
LOK SABHA

COMMITTEE ON EMPOWERMENT OF WOMEN
(2009-2010)

(FIFTEENTH LOK SABHA)

FIFTH REPORT

'WOMEN VICTIMS OF HIV/AIDS'

सत्यमेव जयते

LOK SABHA SECRETARIAT,
NEW DELHI

August, 2010/Bhadrapada, 1932 (Saka)

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Presented to Lok Sabha on 27th August, 2010

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INTRODUCTION

I, the Chairperson of the Committee on Empowerment of Women (2009-2010) having been authorised by the Committee to submit the Report on their behalf, present this Fifth Report (Fifteenth Lok Sabha) of the Committee on the subject 'Women Victims of HIV/AIDS'.

2. The Report is based on the inputs received from the Ministry of Health and Family Welfare (Department of National AIDS Control Organization). The Committee on Empowerment of Women took oral evidence of the representatives of the Ministry of Health and Family Welfare on 27th April, 2010. The Committee also had interaction with NGOs in the field of HIV/AIDS on 10th December, 2009.

3. The Draft Report was considered and adopted by the Committee at their sitting held on 25th August, 2010. The Minutes of the sittings form Part II of the Report.

4. The Committee wish to express their thanks to the Ministry of Health and Family Welfare (Department of National AIDS Control Organization) for placing before them material and information in connection with the examination of the subject and giving evidence before them.

5. For facility of reference, the Observations and Recommendations of the Committee have been printed in thick type in the body of the Report.

NEW DELHI
25th August , 2010
3 Bhadrapada, 1932 (Saka)

SMT. CHANDRESH KUMARI
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

REPORT

A. INTRODUCTORY

Acquired Immune Deficiency Syndrome (AIDS) is an illness caused by the HIV (Human Immuno Deficiency) virus, which weakens the immune system and leads to death through secondary infections such as tuberculosis or pneumonia. The virus is generally transmitted through sexual contact, through the placenta of HIV-infected woman to their unborn child, or through use of contaminated needles (injections) or blood transfusion.

2. The HIV infection results in a broad spectrum of diseases: AIDS is the last, most severe and well-known stage. Hence, not everyone infected with HIV has AIDS. After having been exposed to HIV, the virus can remain in the bloodstream for years without causing any symptom.

3. The existence and rapid spread of HIV and AIDS poses a serious challenge to every nation across the globe. HIV and AIDS have the potential to undermine the massive improvements that have been made in global health over the years. Apart from being a serious health problem, the multi layered effects of the epidemic on the socio-economic fabric of whole nations, makes HIV and AIDS a potential development threat worldwide. The seriousness of the situation and the need to take action has been captured aptly in the following statement by Hon'ble Prime Minister of India, Dr. Manmohan Singh:

> "HIV/AIDS has become a serious socio-economic and developmental concern. We have no choice but to act, and act with firmness, with urgency and with utmost seriousness. To push this effort forward we constituted the National Council on AIDS and I myself head this Council so that the combined attention of the Government as a whole is given to our campaign against AIDS."

"In the absence of a vaccine, the social vaccine of education and awareness is the only preventive tool we have."

4. In this regard, in June, 2001, at the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), 189 national governments signed the Declaration of Commitment on HIV and AIDS. The document commits signatory governments to improve their responses to their domestic AIDS epidemics and sets targets for AIDS-related financing, policy and programming. Public Health Watch, established by the Open Society Institute in 2004, supports independent monitoring of governmental compliance with the UNGASS Declaration and other regional and international commitments on HIV and AIDS. Public Health Watch aims to promote informed civil society engagement in public health policy and practice on HIV and AIDS. The Open Society Institute's Public Health Program promotes health policies based on social inclusion, human rights, justice, and scientific evidence.

5. While the effects of HIV and AIDS are equally detrimental for all persons affected or infected, certain sections of the population, across the world, however, are more vulnerable in terms of both, contracting the infection and subsequent consequences. Both structural (socio-economic, political) and cultural (traditional norms, etc.) factors are responsible for rendering certain sections like, women, commercial sex workers, youth, migrants, truckers, orphans, children and dependants of family members who are positive, more vulnerable than others.

6. Women, whether, married/single, divorced/widowed, sex workers or seasonal migrants or adolescent girls, are most susceptible to the negative impacts – direct or indirect, i.e. infected or affected of HIV and AIDS owing to the dynamics between the structural and cultural factors which places them in a weaker and vulnerable position than most others. Further, women are biologically more prone to HIV infection than men in terms of any single act of unprotected sex with an infected partner with the male-to-female transmission of the virus being 2 to 4 times higher than the female to male transmission among such sero-discordant couples. The biological structure of women

thus also renders them more vulnerable than others to HIV and AIDS. Gender disparities in terms of access to education, resources, income, political power, coupled with incidences of sexual violence, coercion, social dislocation in conflict situations like war etc. or owing to migration for work, serve to increase the risk of HIV infection to women through unprotected sexual intercourse. As a result, women now account for more than half of those living with HIV worldwide and 60% in sub-Saharan Africa. They constitute one-fourth of those infected with HIV in India and one-third in Peru which is indicative of the manner in which gender disparities serve to pose increasing and disproportionate risks to women even in places which have relatively low national prevalence rates.

7. In the context of women and HIV and AIDS, access to the health information, prevention, treatment and care and protection from stigma and discrimination related to HIV and AIDS are some of the aspects which need critical attention across the globe. There has been an increasing realization at the global front regarding the urgent need to address issues related to women in the wake of the rising HIV epidemic which has found place in the national policies of most nations. The government of Ukraine, for instance, has registered considerable success in reducing mother-to-child transmission, with rates declining from 27.8 percent in 2001 (when no interventions were available) to 8.2 percent in 2004.

B. Situational Analysis:Women and HIV/AIDS

8. In India, experts point out that there is no one single epidemic. Instead there are numerous sub-epidemics which are localized in nature reflecting the diverse socio-economic reality of the country. Some significant structural and socio-economic factors serve to exacerbate the existing vulnerabilities to HIV infection:

(i) High poverty levels, with more than 35 percent of the population living below the poverty line;

(ii) Skewed gender relations;

(iii) Large scale migration;

(iv) Low levels of literacy;

(v) Unsafe mobility;

(vi) Lack of awareness;

(vii) Cultural myths, misconceptions, silence and resulting stigma regarding sex, sexuality and HIV;

(viii) Commercial sex and unprotected sex with multiple concurrent partners;

(ix) Male resistance to condom use;

(x) High prevalence of sexually transmitted infections;

(xi) Low status of women, resulting in inability to negotiate safer sex; and

(xii) Women's limited control over and access to economic resources;

9. Since the detection of the first case in Chennai in 1986, the epidemic has spread to all parts of the country from urban to rural areas, infecting the most marginalized especially the poor women, and has moved out to general population from High Risk Groups.

10. The virus has expanded the circle of infected population to include adolescent girls (married and single); married women of reproductive age; sexually active single women; pregnant women, and women survivors of gender based violence, sexual abuse and rape.

11. On this issue, one of the representatives of a NGO working in the field of HIV/AIDS stated during interaction with the Committee as under:-

> "……Women are definitely at risk for many reasons. NACO estimates that there are 2.5 million people who are infected with HIV/AIDS. 87 percent transmissions are through hetro-sexual sex and women are on the receiving end of the total poll here. The data indicates that seven out of 10 women with HIV infections come from poor households both in urban and rural areas……..a few years ago, WHO actually said that one of the biggest factors that one of the biggest issues for Indian women, the risk factor is that they are married because most women who are infected with HIV/AIDS in the country have got infection from their husbands. Studies have repeatedly shown that in our country women are reporting single sexual partners. The impression is that people who have multiple sexual partners are getting infected, whereas in the case of most women this is not true because they are reporting one sexual partner. Also, biologically women are a lot more vulnerable than men. It is much easier for a woman to get infected from a man than the other way round……."

12. HIV transmission in the country is mostly driven by unprotected sexual intercourse and sharing of drug injecting equipment between an infected and an uninfected individual. Not everyone in the population has the same risk of acquiring or transmitting HIV. It occurs within groups or networks of individuals who have higher levels of risk due to a higher number of sexual partners or the sharing of injecting drug equipment. The core High-Risk Groups (HRG) includes:

(i) Female Sex Workers (FSW)

(ii) High-risk men who have sex with men (MSM) and Transgenders (TG)

iii) Injecting Drug Users (IDU)

iv) Bridge Population i.e. Migrants and Truckers

13. The broader transmission of HIV beyond the HRG often occurs through their sexual partners who also have lower risk partners in "general" population. For e.g. a client of a sex worker might also have a wife or other partner who is at risk of acquiring HIV from her higher risk partner. Individuals who have sexual partner are called a "bridge population", because they form a transmission bridge from the HRG to the general population. HRG members may have sexual relationships with different bridge population members, who in turn have at least one partner in the general population. Given this model of epidemic transmission, it is most effective and efficient to target prevention towards HRG members to keep their HIV prevalence as low as possible and to reduce transmission from them to the bridge population.

14. The Ministry of Health and Family Welfare, Department of AIDS Control in their replies furnished to the Committee have informed that HIV/AIDS was first identified in India in 1986. Through serological testing it was found that 10 out of 102 female sex workers (FSW) in Chennai were HIV positive. In 1986, Indian Council of Medical Research initiated the surveillance activity among blood donors and patients with Sexually Transmitted Diseases (STDs). HIV surveillance system in India is the largest HIV surveillance system in the world. HIV surveillance in India started in 1985 when

Indian Council Medical Research (ICMR) for the first time initiated the surveillance activity in blood donors and patients with STDs. Since the establishment of National AIDS Control Organization (NACO) in 1992, sentinel surveillance for HIV/AIDS in India was initiated with sentinel sites confined to selected cities. However, in 1998, NACO formalized annual sentinel surveillance for HIV infection across 180 sites in the country. The monitoring primarily focused upon HIV levels among pregnant women attending antenatal clinics (ANC) and STD patients at STD clinics. Since 2003, the number of sites for sentinel surveillance among high risk groups has been increased. Over the years, the number of sentinel sites were increased from 180 in 1998 to 1215 in 2008.

15. As per the statistical data available, six States viz. Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Manipur and Nagaland have been declared as high prevalence States. High levels were found among FSW and STD patients and Injecting Drug Users (IDU) in Manipur and Nagaland. The concentration of HIV victims has been high among FSW, STD patients and IDU in Manipur and Nagaland. Over the years, HIV epidemic has spread to other States as well and pockets of high prevalence have been identified in different States of northern India. Besides FSWs and IDUs, Men who have Sex with Men (MSM) has emerged as an important high risk group in different parts of the Country. Single Male Migrants and Long Distance Truckers are found to be important bridge population who are vulnerable to HIV.

16. Data since 2003 shows an overall decline in HIV prevalence among Antenatal Clinic attendees at all India level and in high prevalence States. However, rising trend among Antenatal clinic attendees is observed in some low and moderate prevalence States such as Gujarat, Rajasthan, Orissa, Uttar Pradesh, Bihar and West Bengal. In 2008-09, one third of the high prevalence districts have been identified in low prevalence States.

17. The Committee are further informed that among sex workers, there is a decline in HIV prevalence in southern States indicating a possible impact of interventions, while

rising trends are evident in the north-eastern States suggesting a dual nature of the epidemic.

18. MSM with HIV has been identified in high prevalence States as well as in Delhi, Gujarat and West Bengal. Twenty-eight districts have shown five per cent increase in HIV prevalence among MSM group in 2008-09. Total number of Persons Living with HIV/AIDS (State-wise) is given at **Annexure-I**. The State-wise information of total number of deaths reported due to AIDS during the last five years is given at **Annexure-II**.

19. The Committee have been informed that women account for around 39% of estimated 2.31 million people living with HIV/AIDS. Biological, socio-cultural and economic-factors make women and young girls more vulnerable to HIV and AIDS. The HIV virus is more easily transmitted from men to women than from women to men; male-to-female transmission during sex is about twice as likely as female-to-male transmission.

20. On this point, one of the representatives of the NGO who appeared before the Committee stated that:-

> "……..This is because the hetro-sexual transmission of HIV remains by far the most common mode of transmission in India also as in the world. The unequal power balance in gender relations favours men and translates into an unequal power balance in hetro-sexual relations also. This is one of the main things that we have to understand before we venture into why women are more vulnerable…….
>
> Then, coming to women's vulnerability, they are expected to be ignorant about sex in the Indian culture, the culture of silence. They are supposed to be passive in sexual interactions. This is supposed to be the good women model. So, they cannot negotiate safe sex……..
>
> ……the traditional norm of virginity for unmarried girls exist in many societies. This is now increasingly needed to women. Those who are not married, they are required to preserve their virginity and sometimes such people practice anal sex etc. Then, they also do not access treatment services because if they access treatment service for STD, it is highly stigmatizing……..
>
> ……in many cultures, motherhood is a sanctity. The pressure to have a child is always there. Then, economic dependency of women increases the vulnerability to HIV. Research has shown that they are willing to exchange sex for money or favours. It has been shown that men who had experienced

extra-marital sex were 6.2 times more likely to report wife abuse. There have been studies in India which have shown empowering sex workers in India to reduce vulnerability to HIV, STD; the various methods that work, their approaches, mainly educating women; and giving women the skills they need to use a condom, improving women's access to economic resources, ensuring that women have access to health services. So, we have to increase the social status of women and move the topic of violence against women from the private sphere to the public as is being done now…….

FACTORS MAKING WOMEN VULNERABLE TO HIV/AIDS

21. Elaborating further on the vulnerability of women to HIV infection, the Department of AIDS Control has furnished the following information that make women more vulnerable to HIV/AIDS:

i) *Early age at Marriage:* As per 2001 census, 43% of married women were married before the age of 18. Often young women are married to older men who have been sexually active for longer period and are more likely to have acquired Sexually Transmitted Infections(STI)/HIV.

ii) *Negotiating Power:* Prevalent notions of masculinity and feminity generally mean that women have little control or negotiating power in sexual relationships, including marriage. Abstinence and condom use are usually not the options available to women since social norms are that women are not supposed to be sexually knowledgeable.

iii) *Biological Reasons:* Due to biological reasons, women are more susceptible than men to HIV infection in any heterosexual encounter.

iv) *Poverty:* Economic independence acts as a key to management of HIV infection. Often due to absence of resources, women are denied access to services, information and means of livelihood and good nutrition, if HIV infected.

v) *Access to Health Services:* Lack of decision-making and economic constraints set limitations for women to access health services which may be located at some distance from residence and manned by a staff not sensitive to their needs.

vi) *Stigma and Discrimination:* Women experience more stigma and discrimination within the family and outside because of socio-economic norms and values. The stigma and discrimination is compounded for sex workers who are doubly stigmatized and marginalized.

vii) *Widows:* Stigma for widows infected with HIV is widely prevalent and often results in denial of rights over children, property and residence.

viii) *Violence Against Women:* women are subjected to a variety of gender based violence including trafficking, violence at workplace, assault by family members etc. Violence often becomes both a causal factor and result in getting infected.

ix) *Mobility:* Mobility for women is usually limited, which reinforces their lack of access to information and services. At the same time migration, usually increases vulnerability of women. Men, who migrate without families, can bring back the infection, while women who migrate are often at greater risk of sexual exploitation.

x) *Care and Support:* Care of the infected and affected family is undertaken by women and if she is positive her status and conditions becomes more marginal.

22. The Department of AIDS Control has issued a Policy Document and Operational Plan on “Women and HIV” to facilitate mainstreaming of HIV/AIDS under the various programmes of the Government. The purpose of the policy guidelines issued by Department of AIDS Control is to facilitate increased and improved action on the

intersecting issues of HIV/AIDS and women by the NACO; State AIDS Control Societies (SACS); District AIDS Prevention and Control Units (DAPCUs) and the development partners from the non-governmental sector. The guidelines have been developed and framed in consultation with policy and programme personnel of the Government, civil society including people living with HIV, women's organization and the United Nations.

23. According to the above stated policy document and operational plan on 'Mainstreaming HIV and AIDS for Women's Empowerment' by Department of AIDS Control, National AIDS Control Organization (NACO), one-third of the AIDS cases are among the youth in the age group of 15-29 years. Women account for about 39% of all HIV infected population, despite the fact that more than 90% of them are in monogamous relationship. It is estimated that about 30 million men in India buy sex on a regular basis while the social and cultural limits placed on women's sexuality imply that a majority of women abstain from sex before marriage and post marriage remain monogamous. The virus has expanded the circle of infected population to include adolescent girls (married and single), married women of reproductive age, sexually active single women, pregnant women and women survivors of gender based violence, sexual abuse and rape.

II. PSYCHO-SOCIAL AND ECONOMIC IMPACT

24. According to the United Nations Development Programme (UNDP) and National Council of Applied Economic Research (NCAER) study on '*Gender Impact of HIV/AIDS in India'*, women accounted for 70 per cent of the caregivers in HIV affected household (20 per cent of them caregivers are HIV positive themselves) and 79 per cent of the widows were denied a share in husband property. More than 90 per cent of women had stopped living in their marital homes after death of their husbands. It is also found that the percentage of women's illness which goes untreated is higher than that of men. Financial constraints are one of the major reasons for not seeking treatment.

25. Often woman who takes care of HIV infected man becomes sick herself or she is forced to abandon work in formal or informal sectors, with consequent reduction in family income and food security.

26. The Department of AIDS Control has further stated that Unemployment is often the push factor that makes both men and women undertake unsafe practices, making them vulnerable to HIV infection. With loss of income as a result of illness or death of the earning members, often women have to support the family and children. This includes doing low paid unskilled work or being pushed into sex work to meet the needs of the family.

27. The experience of violence, or the fear that it might take place, weakens women in their homes, workplaces and communities leading to an increased vulnerability to coercion, HIV related insecurity and unsafe living conditions. Pervasive gender based violence also limits women and young girls' ability to participate in and benefit from initiatives for HIV prevention and AIDS mitigation. Evidence also suggests that individuals' and communities' demand for HIV related prevention and care services are directly impacted by the stigma surrounding HIV, which largely stems from the social constructs of masculinity and femininity. Often social norms and values reinforce the vulnerable state of women. Some of them that can be enlisted here are as follows:

i) Their contributions to the society as home makers and in their child bearing and rearing role is undervalued;
ii) Casting them in the role of upholders of family honor;
iii) Their identity being limited as wife, mother and daughter;
iv) Fail to recognize their sexuality, or cast their sexual desires and expression in a judgmental framework of 'good' and 'bad' as being immoral and deviant.

III. BEHAVIOURAL CHANGE

28. There exists an inextricable link between human rights, gender and HIV and AIDS. Available evidence establishes beyond doubt that safer sexual practices for HIV prevention can be adopted by individuals and communities on a sustained basis only when the gender relations between sexual partners and their social environment are equitable and based on mutual respect. In view of the vulnerable state of women vis-à-vis spread of HIV/AIDS, it becomes very important that there is behavioural change and meaningful involvement of men, specially when there is near absence of female controlled method of prevention.

IV. STIGMA AND DISCRIMINATION

29. Stigma affects women more intensively than men, preventing them from accessing treatment, information and prevention services. The Department of AIDS Control in their note furnished to the Committee has stated that the construct of 'social evils' produces greater stigma among women because HIV is closely associated with immoral behaviour, such as sex work. This compounds the stigma experienced by women with HIV. Often women are blamed for her husband and/or child getting infected with HIV. In some cases, women experience dual stigmatization – as a widow and a widow who is HIV positive. Issues like control of property rights, residence and care facilities confront the single and widowed women.

30. Mentioned below are some of the factors that contribute to HIV/AIDS- related stigma:

i) HIV is a life-threatening virus and hence people are scared of contracting it.

ii) The virus is associated with behaviours (such as sex with multi-partners and injecting drug use) that are already stigmatised in the society. Sex outside marriage is also stigmatised.

iii) People living with this virus are often held responsible for the infection.

iv) Unlike other leading causes of mortality, HIV selectively affects young adults, the most productive members of society. The effects of ill health

and death among these individuals are amplified because of their dependents.

31. In this connection, a representative of the NGO during interaction with the Committee stated as under:-

> "……..In Andhra Pradesh, Tamil Nadu and Maharashtra, we have seen, though the women contract the disease from their husbands, once the husband dies due to AIDS related illness, the woman will be blamed. They will say that you have not looked after your husband well. That is why he had gone to other women and contracted the disease. Had you managed him well; this would not have happened at all. Most of them are not aware how to inherit the property of their husbands. Once the husband dies, they are thrown out of their homes without any means of support to live. Again, this women will fall into the trap of trafficking or sex work and the cycle continues. That is the situation. So, we were actually thinking of supporting these women by preparing will when they are alive so that their children will have the property right and at least they will survive. That is one thing….."

32. According to the United Nations Development Programme (UNDP), National Council of Applied Economic Research (NCAER) and National AIDS Control Organization (NACO) study (2006) on Gender Impact of HIV/AIDS', the HIV and AIDS-related discrimination, stigmatization and denial appear in a variety of forms, at various levels and in different contexts. The important contexts are the family and the local community, employment and the workplace, and the healthcare system. This stigma has been compounded by fear arising due to lack of knowledge about the modes of transmission of the infection. Because of the stigma attached to it, PLHIV have experienced violent attacks, have been deserted by spouses and families, rejected by communities and workplace, refused medical treatment and been denied even the last rites. Apart from this, stigma and discrimination associated with HIV and AIDS is one of the greatest barriers in preventing further infection and to access the care, support and treatment services that allow PLHIV to lead productive lives. There are evidences to show that stigma and discrimination surrounding HIV and AIDS have particularly left more impact on women. It is seen that knowledge about the right modes of

transmission could reduce stigma and discrimination and help in overcoming the negative attitude towards those infected.

33. The Department of AIDS Control has further stated that NACO has initiated 12 projects related to stigma & discrimination across seven States in January 2009 in collaboration with UNDP. The projects are aimed at understanding HIV related stigma & discrimination against People Living with HIV (PLHIV) and address issues at the institutional and community level. The projects have been launched in the States of Maharashtra, Andhra Pradesh, Tamil Nadu, Rajasthan, Delhi, Karnataka and West Bengal.

34. Mentioned below are the projects being implemented by NACO in collaboration with UNDP:

SNo.	**NGO**	**Geographical Coverage**	**Issues addressed**
1	NAZ Foundation India Trust	New Delhi	Shelter for Children orphaned by HIV/AIDS
2	Society for Promotion of Youth and Masses (SPYM)	New Delhi	Health institutions- Ram Manohar Lohia Hospital & Safdarjung Hospital to address institutional stigma
3	South India AIDS Action Programme (SIAAP)	Chennai, Tamil Nadu	Stigma & discrimination against Women Living with HIV (WLHIV) and Female Sex Workers (FSWs)
4	Vasvya Mahila Mandali (VMM)	Krishna district, Andhra Pradesh	Stigma & discrimination against PLHIV in community
5	Monitoring and Research Systems (MaRS)	Maharashtra	IEC & Media research on Stigma & discrimination
6	International Services Association (INSA)	Karnataka	Empowering Faith Based Organizations (FBOs) & Community Based Organizations (CBOs) & Youth to address stigma against PLHIV
7	SADHANE	Karnataka	Addressing stigma & discrimination in

			community
8	Vasantham Trust	Chennai, Tamil Nadu	Addressing stigma & discrimination in community through children's theatre
9	IMPACT	Jaipur district, Rajasthan	Addressing stigma & discrimination through awareness among adolescents
10	CRESHE	Khammam district, Andhra Pradesh	Addressing stigma & discrimination through children's theatre in rural community
11	CARPED	Medak district, Andhra Pradesh	Addressing stigma & discrimination and HIV awareness among Lambada tribe
12	SAVE Foundation	Sangli district, Maharastra	Reduction in stigma & discrimination through women self-help group empowerment

35. In view of discrimination and stigmatization due to HIV/AIDS, the Committee desired to know whether the Government has any proposal to make a law to punish those who discriminate and maltreat HIV/AIDS victims. In this regard, the Department of AIDS Control has submitted that a draft HIV Bill to protect and promote the rights of people infected or affected with HIV has been finalized but yet to be introduced in the Parliament. The purpose of the Bill is to create a stigma free environment based on the principles of human rights.

C. MOTHER TO CHILD TRANSMISSION OF HIV INFECTION

36. The Committee have been informed that a large number of children are infected from their mothers either during pregnancy or during child birth, a few of them are infected through the transfusion of contaminated blood or its products. As per the 2008 estimates for national adult HIV prevalence, there are about 23 lakhs persons living with HIV, out of which 94,000 are children. A total of 64, 661 children living with HIV are registered, out of which, 19,182 are receiving Anti Reteroviral Treatment (ART) till March, 2010.

37. The Department in their note has stated that an infected child will usually have a positive parent and may also be orphaned by AIDS. NACO has instituted 6 Community Care Centres for HIV positive children and has plans to scale it up further with the support of Ministry of Women and Child Development, Ministry of Social Justice and Empowerment and Ministry of Human Resource Development.

38. Often, children from families affected by HIV/AIDS are forced to drop out-of-school to look after their ailing parents and join the workforce to earn for their families. Another significant reason causing their drop outs are the stigma attached with HIV/AIDS. Depending on the economic condition of the family, these children end up being part of the large number of children from marginalized communities such as street children, children of the sex workers, rag pickers. This in turn leads them to join the 'vulnerable' children/adolescents who are at risk of contracting the disease. Street and working children are forced into child labour (estimated 12.5 million, ILO, 2006), child sex workers (estimated 2-3 million) or other worst forms of exploitation. Lack of information on STI/HIV, peer pressure and lack of access to clinical care increases their vulnerability and risk to HIV infection.

39. The policy on Children and HIV/AIDS was released by Department of AIDS Control and Ministry of Women and Child Development (MWCD) in 2007. The policy lays down a life cycle approach with a goal to provide a sustainable and integrated system of HIV prevention, counselling, testing, care and support to ensure that children who are most vulnerable to HIV infection or who are HIV positive or otherwise affected by HIV/AIDS enjoy the same benefits and opportunities as all other children to develop their potential.

D. INITIATIVES TO ADDRESS THE PROBLEM OF WOMEN WITH HIV/AIDS

40. A key underlying principle of HIV prevention and care programme is the empowerment of women, based on the understanding that when women have more autonomy, they may be better able to make decisions on issues that concern their lives. The empowerment of women hinges on a number of factors including awareness,

information and knowledge, skills, economic viability & independence, control over resources, mobility and decision-making power.

The action plan for ministries, civil society organizations and private sector aims at increasing both access and equity for women and girls.

41. The Department of AIDS Control has submitted that as per NACP III (2007-2012) efforts are being made to create an enabling environment from all sections of the society so that they get fair access to information and services related to HIV/AIDS Campaigns and interventions have been developed to specifically address the vulnerability of HIV among women and the girl child. Culturally sensitive and yet effective use of various forms of Information Education and Communication (IEC) material has been promoted to provide women with key information on HIV. Rural women are specifically targeted through the various IEC campaigns.

I. Awareness Generation among women

42. The success of any programme to prevent the spread of HIV and AIDS depends on improving people's knowledge about HIV and AIDS and their attitude towards those who are already affected. The low level of awareness about the methods of reducing risk of HIV infection has been one of the factors responsible for the spread of HIV. This lack of knowledge about the modes of transmission of HIV and AIDS not only makes women more vulnerable but also leads to negative attitude towards PLWHA and their family. Mentioned below are the initiatives taken by the Department to address the problem of women with HIV/AIDS:

(i) Red Ribbon Express (RRE)-World's largest mass mobilization against HIV/AIDS

43. A specially designed exhibition train on HIV/AIDS, the Red Ribbon Express has been flagged off on 1st December, 2009 from Delhi. The train will cover 152 Stations in 22 States during its journey. The exhibition train has been spreading messages on HIV/AIDS in rural and urban areas through on-board exhibition and outreach activities.

RRE coverage

44. The Department of AIDS Control has furnished the following points about the coverage of RRE in the country:-

(i) RRE has covered 67 stations in the States of Delhi, Rajasthan, Gujarat, Maharashtra, Karnataka, Kerala, Tamil Nadu and Andhra Pradesh (as on 26/04/2010)

(ii) About 21 lakh people reached – out of them about 40% are women.

(iii) 35,800 district resource persons including members of SHGs, PRIs, AWWs, ASHA, Government officials, Teachers, Youth Leaders, NGO Representatives trained on HIV strengthening grass root capacity to respond to the epidemic.

(iv) More than 25,000 people counseled on HIV including 5,000 women; 15,936 tested for HIV including 2,350 women.

(v) About 2,800 people treated for STIs including 900 women

(vi) Over 5,000 people including 1,400 women undergo general health check-up.

45. The Department has further stated that NRHM has also come on board with NACO. Apart from three exhibition coaches with exhibits on HIV and AIDS, there is one coach for counseling and another for conducting trainings of district level resource persons such as members of Panchayati Raj Institutions, Self-Help Groups, Government officials, health workers, youth organizations, teachers, police personnel, etc.

46. Adding further to the facilities being provided by the Red Ribbon Express, the Department has stated that services for HIV counseling and testing, treatment of Sexually Transmitted Infections (STI) and general health check-up are also being provided at the halt stations. Information Education Communication (IEC) exhibition vans and folk troupes have also been deployed to carry messages into rural areas particularly to reach out to those who are not able to come to the railway stations. The response to the project has been overwhelming with thousands of people visiting the train exhibition everyday at the halt stations. The Department has further stated that 21

lakh people have already been reached through the project. Among the people reached through the Red Ribbon Express so far, about 40% are women.

(ii) Radio programmes

47. The Committee have been informed that three radio programmes in Hindi *"Babli Boli"*, *"5 Down Mohabbat Express"* and *"Kitne Door, Kitne Pass"* were launched by NACO, targeting rural women, rural youth and urban migrants respectively. The programmes were aired for six months from September, 2009 to March, 2010. The programmes were linked to the ground mobilization in 21 vulnerable districts, in the States of Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh and Delhi through 100 Radio Listener Clubs formed in each of these districts. The radio clubs promoted not only listenership of the programmes, but also helped in further dissemination of messages in the communities. The States AIDS Control Society (SACS) also produce and air radio programmes on HIV/AIDS in their respective languages.

(iii) Television Programmes:

48. The Department of AIDS Control has submitted that women's issues have been taken up in the TV serial aired on Doordarshan by NACO titled "*Kyonki Jeena Isi ka Naam Hai".* Special episodes on HIV/AIDS are aired in the *Kalyani* Health Magazine, aired from 8 regional networks of Doordarshan. The programme targets rural and semi-urban areas with special focus on women. The evaluation of *"Kalyani"* Health magazine has shown higher knowledge among Kalyani viewers than non-viewers.

(iv) Mid-media and Outdoor:

49. The SACS conducts outreach activities in rural areas through Information Education Communication (IEC) exhibition vans, folk troupes and condom demonstration outlets. In the States through which the Red Ribbon Express passed, these activities were aligned with the RRE project. In addition, hoardings, bus panels, kiosks and information panels are installed by the States to disseminate information on HIV/AIDS.

(v) Materials for Interpersonal Communication:

50**.** Flip Charts on ICTC, ART, STI services are printed by SACS. General information booklets, brochures, folders and short films are produced by SACS and are made available to the target population through service centres, fairs, exhibitions and IEC vans.

(vi) Adolescence Education Programme:

51. The Committee have been informed that the Adolescence Education Programme (AEP) is a key intervention to build skills of the young people and help adolescents cope with negative peer pressure, develop positive behaviour, improve sexual health and prevent HIV infections. Since 2005 NACO in collaboration with Ministry of Human Resource Development (MHRD) scaled up the Adolescence Education Programme, in all States across the country through the Department of Education (DoE) and the State AIDS Control Societies (SACS). Regarding the AEP modules, the following has been submitted by the Department of AIDS Control:

i) The modules introduced in 2005 were subsequently revised in 2008 in view of the suspension of the programme in some States, alleging that educational material being used in the Flip Chart and Teachers Workbook under AEP had select illustrations and exercises which were explicit.

ii) The modules were reviewed by an Expert committee constituted by NACO in consultation with MHRD and NCERT during 2007-08.

iii) The revised prototype material was disseminated to the States for adaptation and contextualization to suit the local needs of students.

iv) Presently, the Adolescence Education Programme continues to be suspended in Chattisgarh, Gujarat, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan and Uttar Pradesh.

v) However, Kerala has resumed the implementation of Adolescence Education Programme.

(vii) Self Help Groups (SHGs)

52. The Department has submitted that Department of AIDS Control through SACS is conducting training/orientation programmes for SHG at the state level in collaboration with Department of Rural Development and Department of Women and Child Development. SHGs are trained on HIV prevention, modes of transmission, HIV related health and stigma and discrimination issues. So far more than 1.5 lakh women from SHGs have been trained in the year 2009-2010. The network of SHGs in Tamil Nadu, Andhra Pradesh and Maharashtra has undertaken outreach programmes for rural women in collaboration with the State Corporation for Development of Women (SCTW).

A representative of the Department of AIDS Control informed the Committee about the training of Self Help Groups during evidence as under:-

> "……..As an additional resource we are utilizing the services of Self Help Groups. There Self Help Groups are trained. There is a cascade model i.e. a module has been devised. At the National level, the State level trainers are groomed. At the State level the district trainers and at the District level women from Self Help Groups are trained….."

(viii) Involvement of Panchayats

53. The Committee desired to know the role of Panchayati Raj Institutions in the awareness generation about HIV/AIDS. In this regard the Department of AIDS Control stated that Ministry of Panchayati Raj has issued a directive for inclusion of HIV/AIDS component in the training programmes of Panchayati Raj Institutions as local grass root leaders the PRIs are instrumental in creating an enabling environment for better service delivery and reduce stigma and discrimination against PLHIV.

54. Adding further to the involvement of Panchayats in awareness generation programmes relating to HIV/AIDS, the representative of the Ministry of Health and Family Welfare (Department of AIDS Control) stated as under:

> "…..we have included a component of 2-1/2 hours on the HIV in the training module meant for the panchayats ……..As per the available information 25,000 members were trained during 2009-2010…….The attitude will change if the opinion makers like panchayats and leaders endorse it."

(ix) Special campaigns in the North-East

55. Special multi-media campaigns aimed at educating youth on HIV and promoting safe behavioural practices were conducted in the States of Manipur, Nagaland and Mizoram. The campaign design involves engaging youth in development and dissemination of HIV messages through music concerts and soccer tournaments which are very popular in the Northeast. Messages were developed and disseminated by youth themselves. The campaigns focused on increasing risk perception about injecting drug use unprotected sex, reducing stigma and discrimination associated attached to HIV/AIDS and promoting HIV related services. The music competitions and football tournaments organized at district level culminated in the State level mega events, which resulted in huge youth participation.

(x) Involvement of ASHAs and AWW in rural areas

56. Among rural women the level of awareness about the transmission routes of HIV infection is much lower when compared with urban women. The position of women in rural areas has been marginalized because of lack of access to education. To reach out to the illiterate women in rural areas public health providers under NRHM play important role to create awareness about HIV/AIDS among rural women. When asked about the training of ASHA and Anganwadi Workers about HIV/AIDS prevention and access to PPTCT, ICTC and to support women living with HIV/AIDS. The Department of AIDS Control has submitted that currently the ASHA training module Vol.1 and 3 have component of HIV covering the aspects: What is HIV infection; how it is passed from one to other person; how it is not passed by; what is risky sexual behavior, window period; sexual route being most common cause of HIV infection; AIDS illness, and its common symptoms; AIDS prevention through community awareness on risk; its seriousness, avoiding sex with multiple partners, consistent and correct use of condoms, availability of counseling; testing and provision of drugs to HIV positive mothers to prevent risk of infection to baby; stigma associated with AIDS.

57. The Department has further stated that NACO in collaboration with Ministry of Women and Child Development has been working towards capacity building of

Anganwadi Workers (AWW) with an emphasis on the prevention, care, support and stigma/discrimination issues related to HIV/AIDS.

II. Condom as a preventive tool.

58. The Committee desired to know how far the use of condom has been instrumental in curtailing the spread of HIV infection. Replying to the query the Department of AIDS Control has stated that, since there is no drug available to prevent HIV/AIDS, therefore, only prevention is the available method from HIV/AIDS and the only prevention tool available is condom. An observation of both Behavioural Surveillance Survey (BSS) data and National Family Health Survey (NFHS) data gives an idea about how the consistent use of condoms have been able to control HIV infection.

59. While heterosexual contact continues to be the main route (87%) of transmission of HIV infection in most parts of the country, the condom is the only prevention method available. The decline in prevalence rate in India, especially in the high prevalence States is attributed to the concerted effort of NACO's targeted Condom Social Marketing Programme (CSMP).

60. Elaborating further on the use of condoms, the Department of AIDS Control has stated that women are not able to negotiate the use of condom with their male partners. In order to address this need, female condoms have been introduced in the country. During examination of the subject, the Committee held interaction with the representatives of some of the NGOs working in the field of HIV/AIDS. During the said interaction, it came out that even within marriage, it is difficult to negotiate consistent use of condom.

In this context, a representative from NGO stated during interaction with the Committee that:-

> "….Within marriage negotiating for condom use because one of the things about HIV prevention all of us talk about all the time is consistent condom use. Even if a woman knows that her husband is not being faithful to her it is very difficult for her to negotiate condom use."

61. The Department of AIDS Control has informed that under NACP-III condom promotion continues to be an important prevention strategy, hence, NACO has launched a number of innovative approaches in promotion of condom use including Female Condoms (FC). Buoyed by the success of its year-long pilot project in high prevalence States, Department of AIDS Control has decided to promote the use of female condoms across the country to control the spread of HIV/AIDS. The Department has further informed that based on the learning's from the pilot project, Government intend to scale up the programme further to 9 States in 2010 to cover 2 to 3 high prevalence districts in each of Delhi, Gujarat, Karnataka, Madhya Pradesh, Assam, Punjab, Haryana, Chhattisgarh and Uttar Pradesh.

62. The Committee have further been informed that the procurement cost of each FC is around Rs. 24, while the Government is providing it at Re. 1 per piece to implementing agencies. Subsidized FCs are available with Female Sex Workers (FSWs) under Targeted Intervention (TI) through their peer educators in the high prevalence States. The Department further informed that Hindustan Latex Family Planning Promotion Trust (HLFPPT), with funding from NACO Social Marketing Organization, is implementing the Female Condom programme in Andhra Pradesh, Tamil Nadu, West Bengal and Maharashtra. It has reached around two lakh Female Sex Workers ensuring 100 percent TI NGOs coverage. The programme focuses on capacity building, training and BCC activities for increasing use of female condoms. In addition to this, with funding from United Nations Population Fund (UNFPA) and subsidized female condoms from the Government of India, the Population Services International (PSI) is also implementing Female Condom scale up programme in Rajasthan, Bihar, Jharkhand and Orissa. Around six lakh female condoms have been reported as sold till January, 2010. Regarding availability of FCs, the Committee further desired to know whether they are available at PHCs and Government hospitals. Responding to the query the Department has stated that FCs are not available in PHCs and Government hospitals.

63. In addition to this various mid-media demand generation activities, efforts are being made to the reduce the consumer's embarrassment to buy a condom from a shop. It is further supported by static mediums like dangler, stickers, posters, wall painting etc. Further, large scale generic mass media campaign has also been launched to support the on ground activities and boost the condom sales and use in prevention of HIV/AIDS, STI and unwanted pregnancy.

III. Anti Retroviral Treatment

64. The Department while deposing before the Committee has stated that Anti-Retroviral Treatment (ART) has changed the attitude of public towards HIV/AIDS as this disease is now seen as a chronic manageable disease. Many positive persons including women, who were otherwise hiding their HIV status are now coming forward for diagnosis and treatment. ART is a combination of three anti-retroviral drugs given in fixed dose combination. ART inhibits the replication of HIV virus and restores the immunity. It cannot eliminate the virus from body but reduces the morbidity and mortality significantly and improves the quality of life.

65. The Committee pointed out that the first case of HIV/AIDS was detected in Chennai in the year 1986 and the Government started treatment of such victims in the year 2004. Thus, several affected people would have been died during this period. In this connection, the Secretary of the Ministry of Health and Family Welfare and DG (NACO) stated as under:-

> "……..that once the anti retroviral treatment begins for a patient, there are chances of that person surviving beyond a certain number of years, it need not be one year. When a persons who starts medication, he or she survives ten, twelve or 13 years. Sometimes, the person dies before that depending upon his general health. 1986 was the first incident of HIV positive in India. Now, between 1986 and 2004, we did not have the treatment. In fact, treatment itself came about in the world as late as in 1998. For 12 years, there was no treatment. So, people who caught it had to die. Mortality rate was high. Till 2004, for anyone who caught it, mortality was sure……..We have done the assessment. After the first year of treatment, 89 percent survived and only 11 percent died. I am talking about the treatment. We have followed them up. It is not curative as you mentioned rightly but the idea of treatment is longevity. We found that after one year, as 89 percent survived and it is as good

as any other developing country……..the question you have asked is extremely important in the sense that the numbers are coming down, how many of them are by deaths and how much of that is actually due to decline in new cases. It is prolonging the survival much more. These are those who have acquired the infection far back and they are reaching the culmination of the illness. The incidence aspect is extremely important and a little more complicated. There is no universally accepted global way of measuring new cases. You have to do a blood test, but you do not know how far back from that blood test did that person get the infection. There is a talk globally now in various technical for a, like the WHO, to have blood assay, etc. They are extremely costly and they are not viable at all. As a surrogate for that, we take the new first delivery of the young mothers, 15 to 19, for the new cases that are coming up. That is what we take as surrogate for the new cases. That is declining. In fact, as of now, it is 0.49 percent of all the pregnancies and amongst them the sub-set is the fresh pregnancies, 15 to 19, which mean that is the fresh case. We are using that as a surrogate for incidence for new cases coming up. So, that is declining. The way we test and find out is we test the blood……."

66. Anti-retroviral Treatment (ART) of persons living with HIV/AIDS was launched on 1st April, 2004 in eight Government hospitals located in six high prevalence States. Since then, the programme has been scaled up both in terms of facilities for treatment and number of beneficiaries seeking ART. Currently, there are 269 fully functional ART Centres across the country.

67. ART is provided by the Department free of cost through ART Centres located mostly in Medical Colleges and District Hospitals. The Department has submitted that 1,20,644 women were on first line ART and 212 women were on second line ART till March, 2010. The Committee have been further informed that there are no ART centre is available in the Union Territories of Andaman & Nicobar, Lakshadweep, Daman & Diu and Dadra & Nagar Haweli. The Committee desired to know the reasons for not establishing any ART Centre in these Territories. The Department while replying to the query has submitted that as in view of less number of HIV patients, full fledged ART Centres have not been established in these Union Territories. However, these Union Territories are being covered under ART programmes through Link ART Centres (LAC). In Dadra and Nagar Haveli, Link ART Centres is functioning at Silvassa and in Daman and Diu, Link ART Centres are being set up.

68. The Department has further submitted that Link ART Centres were not originally planned under NACP-III. Following a study "Assessment of ART centres: Clients' and Providers' Perspectives", which revealed that distance, travel time and costs were main constraints faced by PLHIV, it was decided to set up Link ART Centres (LAC) to facilitate the delivery of ART services nearer to the beneficiaries. Presently, 240 Link ART centre (LAC) have been established and made functional.

69. The Committee desired to know whether 269 ART centres are sufficient to provide treatment to all the PLHIVs in the country In this regard, the Secretary, Department of AIDS Control while tendering oral evidence before the Committee stated as under:-

> "…….Today, we are providing treatment to three lakh people and from the same we have set up 269 ART Centres and each ART Centre can treat 1500 to 2000 people. It is important that highly affected areas such as coastal Andhra Pradesh, some parts of Maharashtra, Northern parts of Karnataka are having more load. But we are making provision for the facility of ART Centre for 1100-1200 or 1300 people because figure of 269 Centre is not permanent. Where there is requirement we are opening new centres……."

70. Adding further regarding the cost of ART, the Secretary, Department of AIDS Control, stated as under:-

> "……..It is Rs. five thousand per year. It is provided free of cost by the Government. The patient does not have to spend on that. Their treatment is done entirely free of cost in Government Hospitals…….Second Line treatment is more expensive it costs Rs. thirty thousand per year. Second Line treatment is also provided in Government Hospitals free of cost….."

IV. Grievance Redressal for PLHIV and WLHIV

71. The Committee have been informed that the Department of AIDS Control has established grievance-redressal mechanism for persons living with HIV/AIDS at the ART Centres following a Supreme Court direction. NACO through GIPA (Greater Involvement of People living with HIV/AIDS) coordinators examine and take up the matter with all those concerned for effective redressal of grievances related to denial of

services, discrimination and stigma. The mode of communication for effective grievance redressal is stated below:

i) Instances of stigma and discrimination are reported to NACO/National Networks/SACS.
ii) GIPA coordinators at SACS examine/investigate and submit a report to the Project Director and copy to NACO (GIPA coordinator), within 10-15 days of the receiving of complaint.
iii) GIPA coordinator at NACO examine/investigate and submit suggestions along with the report within 7 days of the receiving of complaint.
iv) NACO takes the necessary action for effective disposal of the matter.

V. Sensitization of Government Health Care Providers

72. The Committee desired to know whether the Department has any proposal to sensitize Health Care Providers about stigma and violence against women with HIV/AIDS. The Department stated that Government regularly conducts trainings of doctors, nurses and other medical and paramedical staff on HIV/AIDS. One of the major components of training module includes stigma and discrimination and how it adversely affects people living with HIV/AIDS. Moreover, as per the directive of NACO, dated 26th August, 2008, the Medical Council of India (MCI), Dental Council of India (DCI), Nursing Council of India (NCI) and the State/UT AIDS Control Societies have been mandatorily advised to conduct workshops/seminars to sensitize doctors, nurses, other medical and para-medical staff on HIV/AIDS.

VI. Integrated Counseling and Testing Centre (ICTC)

73. An HIV infected person would not know his/her HIV status for a long time unless he/she goes for a blood test. This could be either after a prolonged illness of unknown cause when doctors recommend it or at the time donating blood or during pregnancy. It is therefore important that people are informed and counseled about voluntary testing of HIV. The Department of AIDS Control has submitted that an Integrated Counseling and Testing Centre (ICTC) is a place where a person is counseled and tested for HIV on his

own will or as advised by a medical provider. In India, ICTCs are the first interface point for a person with the entire range of preventive, care and treatment services, provided under the umbrella of National AIDS Control Programme (NACP). The main functions of an ICTC include:-

i) Early detection of HIV;
ii) Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability;
iii) Link People with other HIV prevention, care and treatment services.

74. The Department has further submitted that in 2004 there were 982 ICTCs, the number of such Centres have significantly gone up to 5210 in 2010, making it the largest network of HIV counseling and testing centers in the entire world. As a consequence of this rapid scale up, the number of HIV infected persons who are aware of their HIV status increased from a mere 8% in 2004 to 56% in 2009.

75. The Department of AIDS Control in their replies has submitted that currently 1704 Primary Health Centres (PHCs) are equipped to provide testing facility and counseling services for HIV/AIDS. When asked about the efforts which have been made by the Department to provide testing facilities at all PHCs, the Department has submitted that at present, counseling and testing facilities are available at 1704 PHCs. The target is to provide counseling and testing facilities at 2897 PHCs by 2010-2011. By 2012, it is expected that a total of 4775 PHCs will be offering HIV counseling and testing services.

VII. Community Care Centres

76. The Committee desired to know about the role of Community Care Centers for PLHIV in addressing the problem of HIV/AIDS. Responding to the query the Department of AIDS Control in their replies furnished has stated that Community Care Centres (CCC) play a critical role in providing treatment, care and support to people living with HIV/AIDS (PLHIV). With the mandate of providing a comprehensive package of Care Support Treatment (CST) services, Community Care Centres (CCCs) were set up in the

Non-government sector with the main objective of providing psycho-social support, ensure drug adherence and provide home-based care. Tracing lost to follow-up (LFU) and those missing to get Anti Retro-viral drugs as per schedule was also envisaged in their functioning. Under NACP-III these centres are attached to ART centres and ensure that PLHIV are provided:

i) Counselling for ARV drug adherence, nutrition and prevention.
ii) Treatment of opportunistic infection
iii) Referral and outreach services for follow up and
iv) Social support services.

77. The Department has further stated that the centres are mandated to seek better community and family response towards PLHIV through family counselling. For better treatment outcome, the centres provide families of PLHIV counselling on the patients nutritional needs, treatment adherence and psychological support. From being stand alone short stay home under NACP- III, CCCs have metamorphosed to being a place for providing comprehensive services to PLHIV. These CCCs also play a critical role in enabling PLHIV to access ART, as well as provide monitoring, follow- up counselling support to pre ART and ART patients, positive prevention, drug adherence, nutritional counselling etc.

78. Elaborating further on the role of CCC, the Department of AIDS Control has further stated that with linkages and referrals to ICTCs, Directly Observed Treatment Short-course (DOTS) for TB, Prevention of Parent to Child Transmission (PPTCT), Sexually Transmitted Diseases (STD), Anti-Retroviral Treatment (ART) and other treatment services and interventions, CCC serves as a vital link in providing holistic support to PLHIV with district hospitals and provides referral service to PLHIV when needed. Currently, 300 CCCs are supported under National AIDS Control Programme (NACP) - III.

VIII. Drop-in-Centres

79. The Committee have been informed that NACO is supporting, through SACS, establishment and strengthening of Drop-in-Centres (DICs) which are run by network of people living with HIV. Elaborating further on the role of DICs, the Department has stated that DICs provide a platform for the psycho-social support to PLHIV where they can gather, share their feelings and address their needs. DICs offer opportunities for HIV infected persons to come together share and seek solutions for their problems, avail services and support to get direction for their lives. About 50 percent of the people reached out through these DICs are women. At present, there are a total of 208 DICs operational across the country.

80. Mentioned below are the functions being made available at DICs:

i) To mobilize and enroll PLHIV through community friendly strategies, assuring confidentiality and protecting rights.

ii) To provide specific information related to important issues and services (e.g. prevention of HIV, counseling, nutrition, PLHIV rights, livelihood, treatment, care, education, etc) to PLHIV and their family members.

iii) They also provide counseling services on nutrition, drug adhrerence, legal aid, etc from time to time.

iv) To work with civil society and address stigma and discrimination in various forms against PLHIV.

v) To establish effective functional linkages with existing health care providers (e.g. ICTC, ART centres, CCCs, STI Clinics, PPTCT, etc).

81. Regarding the services being provided to women with HIV, the Department has stated that DICs address the needs of PLHIV, including Woman Living with HIV. Women Living With HIV (WLHIV) are referred for services to STD/RTI, PPTCT, ART etc and for their children to Pediatric ART Centers. In many districts WLHIV are referred and supported for income generation skill development and SHGs have also been formed among WLHIV.

82. When asked whether 208 Drop-in-Centres are sufficient to provide support in view of number of PLHIV in the country, the Department has replied that DICs are opened depending upon the number of PLHIV in a district. New DICs are opened based on the assessment of the needs by SACS, which is periodically reviewed.

83. The Committee further desired to know the state-wise detail of WLHIV who visited DICs across the country, the Department in this regard has stated that currently 50% of all PLHIV in the country are women.

IX. Targeted Intervention for Female Sex Workers

84. The Department in their note furnished to the Committee has informed that mapping of Female Sex Workers indicates that there are roughly 0.8 to 1.2 million female sex workers. Presently the total number of Targeted Intervention (TI) is 682 to reach out to 672,000 FSWs. Through these TIs, women are provided with information about preventive measures to improve negotiating skills and enhance access to condoms. Out of the total TIs, 439 are exclusively for FSWs and rest of the TIs i.e. 243 are composed of other groups including FSWs.

85. The interventions include treatment services for STIs either directly through the project itself or through referral to the nearest public health facility/private practitioner, referrals for counseling and testing for HIV at the ICTCs. NACO has undertaken a targeted approach to reach out to sex-workers, especially women who otherwise are deprived of quality outreach services. These services are provided through a partnership programmes with NGOs which are working in these settings. Reaching all sex workers, especially home and street based, and increasing coverage is an up-hill task as police raids often drive sex workers underground. Efforts are being made to convert at least 50 per cent of the NGO run projects to community based organizations (CBOs) where the community takes responsibility and manages the projects themselves. This is expected to lead to a greater degree of ownership and long-term commitment for sustainable interventions.

X. Targeted Intervention for Migrants

86. As per the Behavioural Surveillance Survey (BSS) 2008, migration has been a major factor contributing to the spread of HIV epidemic in Uttar Pradesh, Bihar and some districts of Orissa and West Bengal. Department of AIDS Control has further stated that there is a need for stronger and focused intervention both at source and destination districts, therefore NACO has planned to design interventions targeting high risk behaviour. The migrant interventions will address unmet needs of returnee migrants, their spouses and the potential ones at source through linking up existing services of Integrated Child Development Services (ICDS), Rashtriya Swasthya Bima Yojana and HIV related healthcare. Intensification of interventions at destination through engaging management structures, informal networks of labourers, contractors, is also undertaken.

87. Currently, there are 206 SACS-funded migrant interventions working with 19.26 lakh migrants in 32 States. The sectors include industries, agriculture and transport in the majority. Besides this, there are 26 interventions funded by USAID in Maharashtra and Tamil Nadu.

XI. Link Worker Scheme

88. The Department of AIDS Control has informed that the Link Worker Scheme (LWS) under NACP-III has been launched to saturate the reach of the HIV related services to the high risk group's vulnerable population based in the rural areas. Based on HIV Sentinel Surveillance 2007, It has been estimated that 57 per cent of the HIV positive persons in India are living in rural areas. This reinforces the requirement of an intensive rural-based intervention for reaching the marginalized groups which remain uncovered even after the expansion of urban based prevention programmes.

89. The LWS envisions a new cadre of workers at the village level, the Link Workers are motivated, community-level, paid female and male youth workers with a minimum level of education, who are able to discuss intimate human relations and practices of sex and sexuality and help equip high-risk individuals and vulnerable young people with information and skills to combat the pandemic. The Link Workers are covering highly

vulnerable villages in districts selected through mapping exercises. They work in each cluster of villages around a 5,000 plus population. They are supported in their work by village-level volunteers selected from the available groups in the community. Presently, the LWS is being implemented with support from United Nations Development Programme (UNDP), United Nations Children Education Fund (UNICEF) and Global Fund for AIDS, Tubercluosis and Malaria (GFATM).

90. The Department of AIDS Control has further stated that the Scheme has been successful in reaching out to rural women and adolescents in most vulnerable districts of the country using inter-personal communication (IPC) and Behaviour Change Communication (BCC) techniques. The Department has further informed that 11,74,252 women have been reached across 126 high vulnerable districts through the LWS.

XII. Programme for Parent to Child Transmission

91. As large number of children are infected from their mother either during pregnancy or during childbirth, the Programme for Parent to Child Transmission (PPTCT) plays important role to prevent transmission of HIV to the child from his/her mother. The Committee have been informed that the programme was initiated as a pilot programme in 2001. The programme involves counseling and testing of pregnant women, detection of HIV positive pregnant women and administration of prophylactic nevirapine to them and their infants, to prevent mother to child transmission of HIV. A statement showing number of beneficiaries of PPTCT Programme is given at Annexure III.

92. In May, 2004 the Programme was expanded to 6 high prevalent States with support from the Global Fund Round II. Now, the programme has been extended all over the country. At present counseling and testing of pregnant women is undertaken in ICTC, which are located in Medical Colleges, District Hospitals and Community Health Centres.

93. The Committee have been informed that there are 0.9 million HIV infected women in India, constituting 39% of the total infected population. There are 27 million annual pregnancies in the country, and 4.6 million (17%) of the pregnant women are covered under PPTCT programme. The estimated number of HIV positive pregnancies is 65,000, out of which 22,506 (34.6%), positive pregnant women have been detected so far. Out of the detected HIV positive pregnant women, 11,517 i.e. 52% have been given ART prophylaxis to reduce the risk of mother to child transmission. Between January and October, 2009, around 42,11,838 pregnant women have been tested and 15,900 pregnant women have been found positive. Out of 15,900 positive pregnant women, 8571 mother-baby-pairs (54%) have been given prophylactic nevirapine.

94. The Committee desired to know the reasons for low coverage of the programme, replying to the query the Department has furnished the following reasons:

i) Large number of home deliveries, particularly in the Northern States, constrains the uptake of pregnant women for PPTCT services.

ii) Uptake of pregnant women is low, except in the six high prevalence States

iii) Integration with National Rural Health Mission (NRHM) remains limited, except in States such as Karnataka and Gujarat

v) Stigma and discrimination towards PLHIV is a major factor impeding progress

vi) Emergency Labour room cases are still not being tested in some States.

95. The Department has further stated that following new initiatives have been planned to detect all HIV positive pregnant women and eliminate transmission of HIV from mother to child.

i) Community based HIV screening by ANM to identify HIV positive cases among pregnant women who do not come to health facilities for antenatal checkups.

ii) Expansion of ICTC services to 24X7 PHC under the 'facility integrated model' in high prevalence districts in collaboration with NRHM to improve access to population living in hand-to-reach areas.

iii) Testing of every direct walk in/emergency labour room cause using the user friendly whole blood finger prick testing.

iv) Convergence with NRHM and securing the involvement of ASHAs in demand generation for PPTCT services through incentive based schemes.

96. The Committee further desired to know about the efforts which have been made by the Department to motivate pregnant women towards ante-natal care and institutional deliveries in the rural areas, the Department in this regard, has furnished that it is mandate of the NRHM to motivate pregnant women to access antenatal care at health facilities and to improve institutional deliveries in the rural areas. The Department has further stated that National AIDS Control Programme (NACP) works in tandem with NRHM and provides counselling and testing facilities to pregnant women who access health facilities.

XIII. National Policy on HIV/AIDS and the World of Work

97. The Department in their note furnished to the Committee has stated that the 'World of Work' has become the most suitable platform for mainstreaming HIV/AIDS because more than 90 percent of HIV infections are in the productive age group. With this view, the Government of India has adopted the "National policy on HIV/AIDS and the World of Work", which was developed by the Ministry of Labour and Employment in consultation with Department of AIDS Control. It is broadly based on code of conduct prescribed by the International Labour Organization and aims to minimize the discrimination against PLHIV at work place. It covers both organized and unorganized sectors and generates awareness about HIV/AIDS, encourage action to prevent its spread and further improve and develop the support and care initiatives at the workplace. The policy aims at preventing transmission of HIV infection amongst workers and their families, protect rights of those who are infected and provide access to available care, support and treatment facilities.

XIV. Legal aid to women living with HIV/AIDS

98. It is often found that the women are blamed for her husband's or child's illness. In some cases, women experience dual stigmatization – as widow and especially a widow of a HIV positive man. Property rights, custody of child, residence and care facilities are some issues which confront the single and widowed women. In view of the problems being faced by WLHIV, the Committee desired to know whether there is any mechanism to provide free legal aid to such women on the issues related to inheritance of property of their husbands, guardianship of children etc. The Department of AIDS Control has stated that for the provision of free legal aid, different States have set off different initiatives. Free legal aid for PLHIV through Legal Aid Cells, Bar Associations or legal aid clinics is being provided in select districts of the States of Chattisgarh, Punjab, Uttar Pradesh, West Bengal, Maharashtra and Tamil Nadu. In Gujarat, an MoU regarding free legal aid to PLHIV has been signed between Gujarat State Network of People living with HIV (GSNP+) and district legal aid authorities.

99. When asked whether the Government has directed other State Governments to provide free legal aid to women living with HIV/AIDS the Department have stated that the States have taken their own initiatives to undertake legal aid for PLHIV. The States have been sensitized on human right issues of PLHIV and have been asked to address these issues through mainstreaming.

On this issue a representative of NGO during the interaction with the Committee expressed his views as under:-

> "…....about women and property rights; women who are positive and who have lost their husbands. In this, there is a model in which that the lawyers collectively are providing free services to fight the cases in the court……Probably, such lawyers' organizations could be supported so that these cases are taken up and the women who have these types of property disputes can take it up and fight out.....…It is not only lawyers' collectively but at the district level there are Legal Aid Cell which provide free service to the people living with HIV. If we can make sensitize, make them strong and provide friendly services exclusively to the women living with HIV, again that would make a tremendous difference to their lives……."

XV. Welfare Schemes for women living with HIV/AIDS

100. The Committee desired to know whether there are schemes to provide financial assistance to women living with HIV/AIDS. In this regard, the Department of AIDS Control has stated that in Orissa, Madhu Babu pension Yojana provides an amount of Rs. 200/- to all PLHIV including women; In Rajasthan the State Government has done away with age consideration for women living with HIV under Widow Pension Scheme. A few States have provided BPL status to PLHIV which help them to access nutritional support and benefits under livelihood schemes.

101. The Department has further stated that the States of Assam, Gujarat, Orissa and Rajasthan are currently providing BPL cards to PLHIV to provide nutritional support. The States of Delhi and Chandigarh are considering to given similar BPL status to PLHIV, now it is still pending. The matter is under consideration in Delhi and Chattisgarh Government. NACO has suggested for automatic inclusion of 'the household with PLHIV as bread earner' as a BPL family to Ministry of Rural Development in response to expert committee report on the methodology for BPL Census 2009.

102. The Committee have also been informed that several efforts have been initiated with different Ministries, both at the Centre and the States. Gender interventions have been afoot with the ministries of Rural Development, Women and Child Development, Road, Transport and Highways, Education, Railways, Social Justice and Empowerment to ensure access to welfare and poverty alleviation schemes for WLHIV.

OBSERVATIONS/RECOMMENDATIONS

103. *Need to expedite the bill for the welfare of People Living with HIV/AIDS*

The Committee find that the stigma relating to HIV affects women more intensively than men, preventing them from accessing treatment, information and prevention services. The construct of 'social evils' produces greater stigma among women because HIV is closely associated with immoral behaviour, such as sex work. Issues like control of property rights, residence and care facilities confront the single and widowed women. The Committee feel that stigma and discrimination associated with HIV and AIDS act as a great barrier in preventing further spread of infection and to the required access for the care, support and treatment services that allow People Living with HIV/AIDS (PLHIV) to lead productive lives. The Committee are disappointed to note that the Government have initiated only 12 projects related to stigma and discrimination against people living with HIV/AIDS in 7 States viz. Maharashtra, Andhra Pradesh, Tamil Nadu, Rajasthan, Delhi, Karnataka and West Bengal in collaboration with United Nations Development Programme (UNDP). The Committee feel that incidences of discrimination against HIV positive persons are prevalent in our society and in spite of efforts made by the Government, they are still on the rise often covertly. The Committee, therefore, recommend that the Government should initiate some more projects of the similar kind which are more intense and focused towards the issue of discrimination in respect of people living with HIV/AIDS, especially women. The Committee further desire that in case of any discrimination against

PLHIV, the responsible person/institution should be held accountable and penalised.

The Committee are happy to learn that the Government is proposing to introduce a Bill in Parliament relating to the issue of stigma and discrimination against women victims of HIV/AIDS. The Committee recommend that the Government should finalise the Bill expeditiously and introduce it in Parliament without any further delay so that the women victims of HIV/AIDS get relief from the highly prevalent stigma and discrimination.

104. ***Need to provide Anti Retroviral Treatment to all children with HIV and increase the number of Community Care Centres for them.***

The Committee note that a large number of children are infected from their mothers either during pregnancy or during child birth and a few of them are infected through the transfusion of contaminated blood or its products. As per the 2008 estimates for national adult HIV prevalence, there are about 23 lakhs persons living with HIV, out of which 94,000 are children. A total of 64, 661 children living with HIV are registered, out of which only 19,182 were receiving Anti Retroviral Treatment (ART) till March, 2010. The Committee further note that NACO has instituted 6 Community Care Centres for HIV positive children and has plans to scale it up further with the support of Ministry of Women and Child Development, Ministry of Social Justice and Empowerment and Ministry of Human Resource Development. The Committee feel that children infected with HIV get trapped in the vicious cycle as they not only suffer pathologically but they are also socially ostracized. The Committee, therefore, recommend that the Government should take necessary steps to provide Anti Retroviral Treatment on

top priority to all the children who are living with HIV/AIDS and also establish more Community Care Centres for Children living with HIV in consultation/coordination with the Ministries of Women and Child Development, Social Justice and Empowerment and Human Resource Development.

105. *Need to conduct a survey to ascertain the impact of AIDS awareness programmes*

The Committee find that the Government have taken many initiatives to generate awareness about HIV/AIDS through wide publicity on the issues relating to the cause of the disease, modes of its transmission, methods for prevention etc. Some of the initiatives taken by the Government to create awareness are Red Ribbon Express, Radio/Television programmes, Adolescence Education Programme, involvement of SHGs and Panchayats, special campaign in north east, involvement of ASHAs/Anganwadi Workers in rural areas etc. The Committee appreciate the efforts made by the Government towards awareness generation initiatives. However, the Committee, feel that in addition to creating awareness about HIV/AIDS, it is equally important to ascertain the impact of such efforts. The Committee, therefore, recommend that the Central Government should direct the State Governments to conduct a quick survey to ascertain the impact of the awareness generation programmes on women in general and the women who have been living with HIV/AIDS. Such a survey will bring out a clear picture of the impact of AIDS awareness programmes and thus help in formulation of effective targeted intervention programmes.

106. *Female Condoms to be made available with ASHAs and special drive needed to promote its use*

The Committee note that unprotected heterosexual contact continues to be the main route i.e. 87 per cent of HIV infection. Therefore, the Committee feel that the only potent preventive tool available in this regard is the use of condoms. The Committee find that woman are not able to negotiate the use of condoms with their male partners. In order to address this need, female condoms have been introduced in the country. The Committee further note that NACO has launched a number of innovative approaches to promote the use of condoms including Female Condoms (FC). The Department of AIDS Control has decided to promote the use of female condoms across the country to control the spread of HIV/AIDS by scaling up the programme further to 9 States in 2010 to cover 2 to 3 high prevalence districts in each of Delhi, Gujarat, Karnataka, Madhya Pradesh, Assam, Punjab, Haryana, Chhattisgarh and Uttar Pradesh. However, it has been found that in our society it is difficult for women to negotiate use of condoms even within marriage. The Committee, therefore, recommend that the Government should take steps to enhance the level of awareness about the benefits of the use of condom and also sensitize the masses so that even females are able to negotiate the use of condoms. The Committee further recommend that the Government should initiate a special drive to popularize the use of female condoms and these should be made available free of cost through ASHAs especially in high prevalence States. This will lead to easy availability of female condoms and women will not be hesitant to procure and use them.

107. *Need to establish more ART Centres for easy access by PLHIV*

The Committee find that Anti-Retroviral Treatment (ART) has changed the attitude of public towards HIV/AIDS as this disease is now seen as a chronic manageable disease. It cannot eliminate the virus from the body but it reduces the morbidity and mortality significantly and improves the quality of life. Many HIV positive persons including women, who were otherwise hiding their HIV status are now coming forward for diagnosis and treatment. The Committee also note that the Anti Retroviral Treatment is available free of cost at Anti Reteroviral Treatment (ART) Centres which are located mostly in Medical Colleges and District Hospitals. At present, there are 269 ART Centres functional across the country. The Committee feel that in view of the number of persons living with HIV/AIDS, 269 ART Centres are not sufficient to provide treatment to all HIV infected persons. The Committee, therefore, recommend that the Government should set up more ART Centres so that more HIV positive persons are able to have an easy access to these Centres for their treatment.

108. *ART Centres to be established in Andaman & Nicobar, Lakshadweep, Daman & Diu and Dadra & Nagar Haveli.*

The Committee find that no full fledged ART Centres have been established in the Union Territories of Andaman & Nicobar, Lakshadweep, Daman & Diu and Dadra & Nagar Haveli. The reason cited by the Government in this regard that there are less number of HIV positive persons in these Union Territories. The Committee also note that the Union Territory of Dadra & Nagar Haveli is covered under Link ART Center which is functioning in Silvassa and a Link ART Centre is also being set up in Daman & Diu. However, the Committee feel that the number

of persons living with HIV/AIDS should not be the criterion for establishing an ART Centre, rather efforts should be made to provide accessibility of ART Centres to PLHIV. The Committee, therefore, recommend that full fledged ART Centres should be established at Union Territories of Andaman & Nicobar, Lakshadweep, Daman & Diu and Dadra & Nagar Haveli.

109. ***Free transport facility to PLHIV to access ART Centres***

The Committee note that presently ART treatment is available at Medical Colleges and District Hospitals in the country. People who are undergoing the treatment have to go to these Medical Colleges and District Hospitals which are not usually located at an easily accessible distance. The Committee also note that some State Governments viz. Orissa, Rajasthan, Assam, Gujarat, Himachal Pradesh and Tamil Nadu have provided free bus travel facility to the people living with HIV/AIDS for travelling to ART Centres for their treatment. The Committee feel that often women living with HIV are not able to have an access to the information and services due to lack of mobility and financial constraints. The Committee, therefore, recommend that the Government should instruct all the State Governments to provide free bus passes to HIV positive persons so that they can easily travel to the ART Centres for their treatment. This will certainly help PLHIV in general and women victims in particular whose mobility is limited due to financial constraints.

110. *All PHCs in pockets with high concentration of PLHIV to have ICTCs*

The Committee note that Integrated Counseling and Testing Centres have been established, where a person is counseled and tested for HIV on his own will or as advised by a medical practitioner. In India, ICTCs are the first interface point for a person with the entire range of prevention, care and treatment service, provided under the umbrella of National AIDS Control Programme (NACP). The ICTCs are available in Medical Colleges, District Hospitals and Community Health Centres and few Primary Health Centres (PHCs). The Committee, further note that presently only 1704 PHCs are equipped with the facility of testing and counselling services of HIV/AIDS. The Committee feel that sufficient ICTCs are not available spread across the country and, therefore, they are not easily accessible to the people living with HIV/AIDS. The Committee recommend that the number of ICTCs should be increased across the country and more and more such Centres should be established in the high prevalent States. The Committee also recommend that pockets with high concentration of PLHIV should be identified and all PHCs in such areas should be provided with the facility of testing and counselling services of HIV/AIDS.

111. *Need to establish more Community Care Centres*

The Committee find that Community Care Centres act as stand alone short stay home for PLHIV and play a critical role in enabling PLHIV to access ART, as well as provide monitoring, follow-up counselling support to pre ART and ART patients, positive prevention drug adherence, nutritional counseling etc., The Committee note that 300 Community Care Centres have been established to

provide treatment to HIV positive persons. However, the Committee feel that in view of large number of persons infected with HIV, the number of Community Care Centres i.e. 300 is not adequate to cater to the health needs of the people living with HIV. The Committee, therefore, recommend that the Government should direct State Governments to establish more Community Care Centres to provide adequate support to the people living with HIV/AIDS.

112. *Need to provide Vocational Training to People Living with HIV/AIDS*

The Committee note that women account for more than 70 per cent of caregivers when it comes to providing care to PLHIV. It is a matter of concern that nearly 20 per cent of caregivers themselves are HIV positive. They also need social safety net and means for sustainable livelihood. With loss of income as a result of illness or death of the earning member, women have to very often support their family in whatever way they can. This may include doing low paid unskilled work or being pushed into sex work to meet the financial needs of the family. The problems of PLHIV are compounded due to lack of family income and employment opportunities. The Committee feel that efforts need to be made to provide some vocational skills to AIDS victims with special focus on women so that they can hope for a better future and reliable means to feed their families. The Committee, therefore, recommend that vocational training should be provided at each Community Care Centre in the high prevalent States so that PLHIV specially women can acquire practical skills for income generation.

113. ***Need to establish more Drop-in-Centres along with a special desk for women visitors***

The Committee find that the Department of AIDS Control through State AIDS Control Societies (SACS) has been supporting establishment and strengthening of Drop-in-Centres (DICs). These centres offer opportunities for HIV infected persons to come together, share and seek solutions for their problem, avail services and support to get direction for their lives. The Committee also note that about 50 percent of the people who reach out to these DICs are women. At present, there are a total of 208 DICs operational across the country. The Committee feel that in view of number of HIV positive persons and the fact that 50% of the visitors are women, 208 Drop-in-Centres are not sufficient. The Committee, therefore, recommend that Government should impress upon the State Governments to take steps to establish more DICs for the HIV positive persons along with a special help desk for women visitors.

114. ***Need to organize Health Melas for testing of HIV/AIDS at CHC level once in three months***

The Committee find that the large number of home deliveries is a major reason for low coverage of the programme of Prevention of Parent-to-Child Transmission (PPCT) particularly in the Northern States. Although, public health providers under NRHM i.e. ASHAs, ANMs, AWWs have already been involved to create awareness among women for institutional deliveries in rural areas, the uptake of pregnant women for institutional deliveries is not so encouraging. The Committee, therefore, recommend that the Government should give directions to the Health Departments of the State Governments to organize Health Melas for

testing of HIV/AIDS at CHC level once in three months to identify pregnant women living with HIV infection. This will be helpful while providing them PPCT coverage.

115. *Special incentive for grass root workers like ASHAs, ANMs and AWWs for getting HIV test done for pregnant women.*

The Committee note that a large number of children are infected from their mother either during pregnancy or during childbirth, the programme for Prevention of Parent to Child Transmission (PPCT) plays an important role to prevent transmission of HIV to the child from his/her mother. The programme involves counselling and testing of pregnant women, detection of HIV positive pregnant women and the administration of prophylactic nevirapine to them and their infants, to prevent the mother to child transmission of HIV. The Committee also find that there are 27 million annual pregnancies in the country and 4.6 million (17%) of the pregnant woman are covered under programme for Prevention of Parent to Child Transmission (PPCT). From January, 2009 to October, 2009 only 8,571 Mother Baby pairs (54%) were given prophylactic Nevirapine out of 15,900 positive pregnant women. The Committee find that the low coverage of pregnant women under PPCT is mainly due to the large number of home deliveries in northern India, emergency cases at labour room and limited integration with National Rural Health Mission (NRHM). The Committee feel that public health providers like ASHAs, ANMs and AWWs can play an important role in motivating women in rural areas for institutional deliveries and voluntary testing of HIV during pregnancy. The Committee, therefore, recommend that health workers like ASHA and other grass root functionaries like AWWs and

ANMs should be incentivized specifically for getting a pregnant woman tested for HIV during pregnancy.

116. *Legal Aid to women living with HIV/AIDS*

The Committee find that often woman is blamed for her husband's or child's illness associated with HIV infection. According to a study conducted by United Nations Development Programme (UNDP), ninety per cent of women who were widowed as a result to their husband's death due to AIDS have stopped living in their marital house. Women living with HIV/AIDS usually face problems on the issues relating to inheritance of property of their husband and custody of their child. The Committee find that legal help is being provided to people living with HIV infection through Legal Aid Cells, Bar Associations or Legal Aid Clinics in the States of Chattisgarh, Punjab, Uttar Pradesh, West Bengal, Maharashtra, Tamil Nadu and Gujarat. The Committee appreciate the efforts made by these State Governments and recommend that the Central Government should direct the other State Governments to follow suit and give instructions to their Law Departments to establish Special Legal Cells to provide free legal aid to people living with HIV infection .

117. *BPL status to people living with HIV/AIDS*

The Committee observe that some States viz. Assam, Gujarat, Orissa and Rajasthan are currently providing Below Poverty Line (BPL) Cards to people living with HIV/AIDS to provide nutritional support. The Committee note that the Department of AIDS Control has suggested for automatic inclusion of the "household with People Living with HIV/AIDS as bread earner" as a BPL family to

the Ministry of Rural Development in response to the report of the expert committee on the methodology for BPL Census, 2009. The Committee feel that nutritional support is an essential component of treatment of people living with HIV/AIDS. The Committee, therefore, recommend that the Government should give direction to all the State Governments to provide BPL status to 'the house hold with PLHIV as bread earner'.

118. *Pension Scheme for people living with HIV/AIDS*

The Committee note that financial help is being provided to Women Living with HIV/AIDS under the Madhu Babu Pension Yojana in Orissa by giving an amount of Rs. 200/- pension per month. The Government of Rajasthan has done away with the age consideration for Women Living with HIV under Widow Pension Scheme. While appreciating the efforts made by the States of Orissa and Rajasthan the Committee is of the firm opinion that a mere financial help of Rs. 200/- in the form of pension is not enough to meet the requirements of HIV positive persons as they require to spend on treatment, nutritional diet, etc. The Committee, therefore, recommend that the Government should formulate a Pension Scheme for Persons living with HIV/AIDS and the amount of the pension should not be less than Rs. 600/- per month.

NEW DELHI
25 August , 2010
3 Bhadrapada,1932(Saka)

SMT. CHANDRESH KUMARI
CHAIRPERSON
COMMITTEE ON EMPOWERMENT OF WOMEN

Annexure – I

Sex-wise Distribution of HIV+ as per data of ICTC

	2002-03			2003-04			2004-05			2005-06			2006-07			2007-08			2008-09		
State	Children	Male	Female	Children	Male	Female	Children	Male	Female	Children	Male	Female	Children	Male	Female	Children	Male	Female	Children	Male	Female
Andaman & Nicobar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	23	11
Andhra Pradesh	899	14130	9845	1458	22810	16412	2349	32357	24626	3899	48374	38225	6422	67751	55236	6660	68171	55190	1080	42759	33354
Arunachal Pradesh	0	0	0	0	0	0	0	0	0	2	3	4	1	9	6	1	5	1	1	10	8
Assam	1	56	23	13	123	64	11	156	71	19	276	140	30	516	225	28	349	152	51	586	269
Bihar	82	747	341	127	1156	618	85	1167	615	232	2649	1681	366	3531	2260	281	2807	1826	412	4157	2597
Chandigarh	57	420	275	63	443	270	72	515	271	134	941	559	126	985	569	74	531	320	107	798	414
Chhattisgarh	0	0	0	0	80	26	26	240	145	21	303	168	70	657	367	138	806	530	149	1107	580
Dadra & Nagar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	44	25
Daman & Diu	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	25	11	7	45	26
Delhi	187	2332	827	200	1992	773	253	2280	1077	333	3295	1544	453	5120	2415	461	4895	2457	403	4857	1765
Goa	51	773	433	52	659	421	69	551	320	51	552	410	80	756	423	64	587	338	73	642	401
Gujarat	484	4554	2150	489	4368	2222	455	3995	2187	846	8603	4444	1150	9885	5023	946	7204	4075	1032	10130	5322
Haryana	40	366	174	58	489	241	124	744	430	155	1041	649	274	1680	1118	302	1961	1305	213	1905	1145
Himachal Pradesh	10	135	107	36	209	174	44	241	228	46	310	252	73	337	322	114	291	331	79	314	271
Jammu & Kashmir	7	198	104	21	210	135	14	206	95	23	254	145	44	358	229	49	316	188	39	348	166
Jharkhand	0	7	0	10	75	25	15	180	100	43	342	203	109	544	384	119	672	477	197	1495	1119
Karnataka	275	4371	2756	340	8120	4926	829	9943	6654	1001	11359	7899	803	6007	4536	1290	8657	7499	2559	22124	17970
Kerala	15	162	78	37	240	153	110	630	506	209	1419	1020	230	1848	1490	167	1547	942	134	1736	1013
Madhya Pradesh	63	601	293	87	709	327	141	935	513	257	1463	873	211	1765	1082	196	1199	778	262	2147	1254
Maharashtra	1055	15818	7429	1443	17776	8897	1942	19497	10780	2420	23342	13355	4596	35390	23337	3247	23756	15902	5959	45990	30803
Manipur	176	1576	889	313	2097	1453	742	3563	2095	442	2320	1721	520	2439	2004	776	2336	1767	129	503	429
Meghalaya	0	1	0	0	3	0	0	4	0	2	2	4	3	16	14	0	34	9	3	35	40
Mizoram	15	207	127	14	211	139	10	251	179	25	371	261	39	402	277	27	351	272	34	488	265
Nagaland	3	61	40	23	198	175	46	407	392	69	657	644	100	659	648	79	452	492	93	747	669
Orissa	10	125	32	48	398	190	58	686	326	184	1337	708	247	2238	1284	234	2237	1260	286	2251	1246
Pondicherry	30	462	249	40	316	184	15	193	108	67	481	316	66	640	360	40	412	235	50	484	327
Punjab	21	203	119	51	353	219	91	506	334	119	697	505	336	1917	1275	442	2493	1968	401	3114	1823
Rajasthan	26	183	90	18	189	87	63	528	275	277	1902	1001	402	2919	1790	574	3054	2186	673	4527	2965
Sikkim	0	10	0	0	4	2	2	7	0	1	15	3	0	24	7	0	15	7	1	31	15
Tamil Nadu	683	13641	7239	984	17529	10281	1599	20763	13529	783	14014	10653	1821	32265	24354	1743	22142	16650	1562	22241	14074
Tripura	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	43	20
Uttar Pradesh	89	1215	594	106	1454	753	198	1762	963	287	2452	1429	472	3548	2421	812	5492	3969	773	5962	4078
Uttaranchal	6	30	18	12	264	93	72	259	143	30	180	131	28	224	136	47	253	179	56	372	236
West Bengal	30	457	214	85	556	326	89	1264	634	221	1996	1356	314	2652	1975	265	2048	1621	390	3698	2263
Total	4315	62841	34488	6328	83035	49626	9524	103836	67646	12198	130950	90303	19386	187082	134477	19177	164880	122888	17216	186013	126968

Annexure –II

State-wise information of total no. of deaths due to AIDS during last five years is as follows:-

States	Total no. of AIDS Deaths				
	2005	2006	2007	2008	2009
A&N Island	6	0	0	0	0
Andhra Pradesh	412	564	752	461	53
Arunachal Pradesh	0	6	0	2	0
Assam	0	0	5	39	67
Bihar	0	0	0	0	0
Chandigarh	27	34	116	95	110
Chhattisgarh	6	3	9	9	6
D & N Haveli	0	0	0	0	0
Daman & Diu	0	0	0	0	0
Delhi	46	18	163	133	48
Goa	85	21	131	108	130
Gujarat	130	31	76	100	39
Haryana	0	0	0	0	0
Himachal Pradesh	26	2	17	4	1
Jammu & Kashmir	0	0	42	39	61
Jharkhand	0	11	35	68	84
Karnataka	172	0	0	0	0
Kerala	0	0	0	0	0
Lakshadweep	0	0	0	0	0
Madhya Pradesh	15	55	38	26	18
Maharashtra	306	216	508	838	1117
Manipur	39	48	64	10	0
Meghalaya	0	0	4	10	9
Mizoram	24	30	26	14	0
Nagaland	3	0	26	35	33
Orissa	177	81	58	0	0
Puducherry	0	0	0	0	0
Punjab	13	24	18	4	0
Rajasthan	25	37	38	32	32
Sikkim	0	2	1	0	0
Tamil Nadu	187	768	0	0	0
Tripura	0	0	0	3	16
Uttar Pradesh	0	0	2	0	0
Uttarakhand	9	2	21	10	22
West Bengal	140	113	11	30	82
Total	**1,842**	**2,066**	**2,161**	**2,070**	**1,928**

Source: CMIS, NACO

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Annexure III

India PPTCT Data for 2009 (January to December) Source: CMIS NACO

No.	Name of State	ANC Registrations	Number of pregnant women counselled for HIV in ICTCs	Number of pregnant women tested for HIV in ICTCs	Estimated number of HIV positive pregnant women (Under revision by WHO India)	Number of pregnant women detected positive for HIV out of the tested	Number of MB pairs who were given ARV Prophylaxis out of detected	% of MB pairs who were given ARV prophylaxis out of detected
1	Andhra Pradesh	640536	622273	614965	12172	3986	2826	70.90
2	Arunachal Pradesh	9419	9129	8829	12	3	0	0.00
3	Assam	137269	120001	116680	0	87	41	47.13
4	Bihar	266991	140163	116267	3644	332	94	28.31
5	Chandigarh	21607	19400	19255	41	47	38	80.85
6	Chhatisgarh	62227	45492	42378	1101	155	56	36.13
7	Delhi	260923	170441	165616	704	397	224	56.42
8	Goa	11810	10987	10885	116	58	53	91.38
9	Gujarat	396581	365103	361200	3594	930	481	51.72
10	Haryana	109892	77062	73539	800	98	31	31.63
11	Himachal Pradesh	31427	28666	28164	27	31	13	41.94
12	Jammu & Kashmir	108394	26826	26036	74	23	10	43.48
13	Jharkhand	31921	38067	30751	682	50	38	76.00
14	Karnataka	624316	629899	622853	7261	2870	1788	62.34
15	Kerala	116040	101532	99369	989	97	78	80.41
16	Madhya Pradesh	254045	133889	113564	1960	154	82	53.25
17	Maharashtra	903453	875527	836723	10950	3468	2498	72.03
18	Manipur	49516	47498	47381	375	260	187	71.92
19	Meghalaya	14025	6408	4180	34	18	9	50.00
20	Mizoram	18592	15557	15248	80	131	69	52.67
21	Nagaland	18889	18707	18287	308	187	126	67.38
22	Orissa	212953	155090	132652	1236	204	86	42.16
23	Pondicherry	35117	15418	15098	55	19	16	84.21
24	Punjab	101060	88662	88035	309	193	95	49.22
25	Rajasthan	362049	254383	218550	2374	329	177	53.80
26	Sikkim	5860	6821	6495	9	5	2	40.00
27	Tamil Nadu	1099231	1091074	1080510	5631	1626	1594	98.03
28	Tripura	4839	4707	4676	76	6	0	0.00
29	Uttar Pradesh	501502	362251	312659	3722	464	205	44.18
30	Uttarakhand	35010	33537	31354	130	42	19	45.24
31	West Bengal	397154	273422	254389	6679	373	171	45.84
	Total	6842538	5787992	5516588	65065	16593	11077	66.75

ANNEXURE-IV

MINUTES

COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)

Fifth Sitting
(10.12.2009)

The Committee sat on Thursday, the 10th December, 2009 from 1500 hrs. to 1630 hrs. in Committee Room 'D', Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Shruti Choudry
3. Smt. Ashwamedh Devi
4. Smt. Rama Devi
5. Dr. Jyoti Mirdha
6. Kumari Meenakshi Natrajan
7. Smt. Jayshreeben Kanubhai Patel
8. Smt. Sushila Saroj
9. Smt. Annu Tandon

RAJYA SABHA

10. Shri Ambeth Rajan

WITNESSES

NGOs

1. Ms. Anjali Gopalan
   Executive Director
   Naz Foundation (I) Trust

2. Ms. Elizabeth Sime
   Country Director
   CARE India

3. Ms. Padma Buggineni
   Programme Manager
   India HIV/AIDS Alliance

SECRETARIAT

1.	Shri S. Bal Shekar	Joint Secretary
2.	Smt. Mamta Kemwal	Deputy Secretary
3.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee to the sitting.

3. Then the representatives of the NGOs were invited to the sitting. After their welcome Hon'ble Chairperson requested them to apprise the Committee on various aspects of the subject 'Women Victims of HIV/AIDS' such as; awareness among women about HIV/AIDS; access to health services; social support for women victims; challenges being faced by the organizations while dealing with such women victims. Thereafter, they shared their views/suggestions on these aspects and replied to the subsequent queries of the Members of the Committee.

4. A verbatim record of the proceedings has been kept.

The Committee then adjourned.

ANNEXURE V

MINUTES

COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)

Twelfth Sitting
(27.04.2010)

The Committee sat on Tuesday, the 27th April, 2010 from 1500 hrs. to 1700 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Smt. Ashwamedh Devi
3. Smt. Rama Devi
4. Smt. Sumitra Mahajan
5. Dr. Jyoti Mirdha
6. Shri Sidhant Mohapatra
7. Kumari Meenakshi Natrajan
8. Smt. Jayashreeben Kanubhai Patel
9. Smt. Rajesh Nandini Singh
10. Smt. Seema Upadhyay

RAJYA SABHA

11. Smt. Shobhana Bhartia
12. Smt. Brinda Karat
13. Dr. Prabha Thakur

WITNESSES

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF AIDS CONTROL)

1.	Shri K. Chandramouli	Secretary & Director General (NACO)
2.	Ms. Ardhana Johri	Joint Secretary

SECRETARIAT

1.	Shri C.S. Joon	Director
2.	Smt. Mamta Kemwal	Deputy Secretary
3.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, the Chairperson welcomed the representatives of the Ministry of Health and Family Welfare to the sitting of the Committee.

3. Thereafter, the representatives of the Ministry gave a brief presentation and tendered oral evidence on the subject 'Women Victims of HIV/AIDS' before the Committee. The main issues which came up for discussion during the course of evidence included HIV prevalence in the country; awareness among women about HIV/AIDS; access to ATR Centres and their availability in the rural areas; Counseling and Testing of pregnant women under Parent to Child Transmission Programme; mapping of female sex workers, high risk groups and Migrants; Targeted Intervention and Link Worker Scheme for community participation; etc.

4. Members sought clarifications on different points, some of which were replied to by the representatives. The Ministry was also asked to furnish written replies to the remaining queries.

5. A verbatim record of the proceedings of the sitting has been kept.

The Committee then adjourned.

ANNEXURE VI

MINUTES
COMMITTEE ON EMPOWERMENT OF WOMEN (2009-2010)
Twentieth Sitting
(25.08.2010)

The Committee sat on Wednesday, the 25th August, 2010 from 1500 hrs. to 1600 hrs. in Room No. 130, Chamber of Hon'ble Chairperson, Committee on Empowerment of Women, Parliament House Annexe, New Delhi.

PRESENT

Smt. Chandresh Kumari - Hon'ble Chairperson

MEMBERS

LOK SABHA

2. Shrimati Shruti Choudhry
3. Shrimati Ashwamedh Devi
4. Shrimati Rama Devi
5. Shrimati Jyoti Dhurve
6. Dr. Jyoti Mirdha
7. Kumari Mausam Noor
8. Shrimati Rajesh Nandini Singh
9. Shrimati Annu Tandon

RAJYA SABHA

10. Shrimati Brinda Karat
11. Dr. Prabha Thakur

SECRETARIAT

1.	Shri S. Bal Shekar	Additional Secretary
2.	Shri C.S. Joon	Director
3.	Smt. Mamta Kemwal	Deputy Secretary
4.	Smt. Reena Gopalakrishnan	Under Secretary

2. At the outset, Chairperson welcomed the Members to the sitting of the Committee.

3. The Committee then took up for consideration the draft Report on the subject **'Women Victims of HIV/AIDS'**. After some deliberations, the Committee adopted the draft Report with some changes and authorised the Chairperson to finalise the Report and present the same to the Parliament.

4. The Committee then adjourned.