CHAPTER - 4 PUBLIC AWARENESS PROGRAM IN GUJARAT AND ROLE OF NGOs

4.1.1 Introduction

Every society is concerned about its health. Every human community also has unique customs and beliefs about illness, health, and treatment. Ever since the dawn of time, people have attempted to control illnesses. In an effort to provide solace by curing illnesses, herbalists, shamans, magicians, priests, and medicine men all made different attempts. In traditional culture and civilization, the bulk of beliefs in medicine were magical and religious. In modern society, medical sciences generally deal with health, medication, and treatment. However, for a variety of cultural, social, and economical reasons, people reject professional advice and modern medical procedures. As a result, social sciences surely have an interest in health.

HIV stands for "Human" (exclusive to the genus Human). Being immune deficient or unable to defend oneself against infectious agents AIDS is an acronym for acquired (requires action to contract) disease-causing agent known as a virus. being able to prevent infectious diseases (Syndrome); deficiency (absence); a set of symptoms and indicators of a disease. Since most nations have officially recognized the HIV/AIDS epidemic, no nation is exempt from the scourge of this illness at the moment. In the United States, AIDS was first scientifically recognized as a modern epidemic in 1981. The first confirmed case involving female sex workers (FSWs) was discovered in Madras, India, in April 1986. However, the first case of AIDS was discovered in 1987.

4.1.2 AIDS Awareness Program in Gujarat

Gujarat's industrial development has created a significant risk of HIV/AIDS transmission. People are moving to Gujarat in search of employment from all over India. In a similar vein, Gujaratis have a strong inclination to migrate overseas. In such cases, people may choose to have sex outside of marriage, which increases their risk of HIV/AIDS. In 1986, the first recorded case of AIDS in Gujarat was at Ahmedabad Civil

Hospital. Subsequently, as HIV/AIDS has become more common in various districts of Gujarat. The highest rate of HIV/AIDS is found in Gujarat's largest city, Ahmedabad, and is followed in order by Surat, Rajkot, Jamnagar, Vadodara, and Junagadh.

In order to carry out Phase-I of the National AIDS Control Programme in compliance with a state Family Welfare Department resolution dated July 13, 1993, and to evaluate the severity of HIV/AIDS, the government of Gujarat established the State AIDS Cell (SAC) in December 1992. SAC implemented the program in accordance with the guidelines set forth by the National AIDS Control Organization (NACO) and with the approval of the State Empowered Committee, which was established at the State level for the same purpose.

To guarantee the program's prompt and effective execution, the government asked NGOs to participate and cooperate in the fight against AIDS. The State AIDS Empowered Committee resolved to register the current State AIDS Cell as a society on August 27, 1998. The Indian government also recommended setting up a State AIDS Control Society to help carry out the program, especially the second phase that began in April 1999. The National AIDS Control Programme has been implemented since then by the State AIDS Control Society (GSACS). The Gujarat government manages several programs aimed at managing and preventing HIV/AIDS. Gujarat's primary initiatives are: 1. Targeted Intervention (TI), 2. ICTC, 3. STI Care Services, 4. Blood Safety Programme, 5. Information, Education & Communication, 6. Red Ribbon Club Programme, 7. Health Education and Life skill Programme (HELP), 8. Link Worker Scheme (LWS), 9. Care, Support and Treatment: Anti-Retroviral Therapy (ART) Centre and Link ART Centre (LAC) and 10. Community Care Centres (CCC). The goals of each of these initiatives are HIV/AIDS awareness, prevention, and control.

4.1.3 Public Awareness and HIV/AIDS

Medical sociology studies the ways in which culture and society influence health and illness. It also examines circumstances involving medical conditions. Without a doubt, a person's sociocultural environment has an impact on their morbid conditions.

The emergence of the disease was once linked to natural, supernatural, religious, and magical factors. However, during the industrial revolution, people's faith in traditions, customs, and other folk practices began to wane and be replaced by more rational considerations as urbanization and the spread of Christianity increased. Consequently, medical science began to progress as an applied science.

Numerous studies have been conducted regarding the illness, its management, and its prognosis. Social science researchers are studying social dynamics, interactions, and behavior patterns concurrently in an attempt to identify risk behaviors that might make particular populations more vulnerable to HIV/AIDS and to encourage behavior modification. In this context, it becomes evident that human behavior can affect the path of the pandemic, despite the fact that this is a very broad and poorly understood concept.

David Mechanic (1968) discussed the prevalence of disease diffusion and sociocultural reactions to the patient in his book Medical Sociology. Unaware of their status, HIV positive individuals can occasionally spread the virus to their partners, children, and other family members. When infected individuals move around and potentially infect others, they carry the infection, which is how the infection spreads from one geographic area to another. People who relocate from areas with a higher HIV prevalence to areas with a lower prevalence are generally more likely to get the virus than people who remain in the higher prevalence regions, according to studies on mobility and infectious diseases. If contagious, the infected individuals may also infect others, which is how they will spread the infection by carrying it with them. Migration has a big impact on high-risk sexual behavior.

The State AIDS Control Societies and the NACO both contribute significantly to the management and prevalence of HIV/AIDS through awareness campaigns. High Risk Groups (HRGs) such as Female Sex Workers (FSWs), Men Having Sex with Men (MSM), Truckers, Migrants, and Injected Drug Users (IDUs) are the main carriers of HIV/AIDS. Nevertheless, we are unable to identify the high-risk group's members. There is a significant chance that anyone could get HIV or AIDS. In order to prevent and

manage HIV/AIDS, there must be public education. There is a lot of migration in society as a result of the urbanization and industrialization processes. It is not mobility per se that makes people more vulnerable; rather, it is the act of moving that puts people in circumstances where they are more likely to participate in high-risk behavior. From the source to the transit point to the destination and back to the starting point, there is a complex interaction of movement that must be understood in the context of the sociocultural meaning that people attribute to this physical movement. For example, it is important to understand people's origins, the reasons behind their migration, the ways in which they stay connected to the people they live with while they are away, the places they visit, the ways in which they maintain their health while traveling, the places they go, the living and working conditions at their destination, the social environment that is created there, the importance they place on returning to their place of origin, and the ways in which they adapt once more. People become more vulnerable to the infection as a result of being cut off from their families. The population that travels may encounter a variety of circumstances that could increase their susceptibility to infection. These could include a lack of access to health care, obstacles based on culture and language, the use of money to buy drugs or engage in sexual activity, prejudice related to immigration status, or HIV status that is real or believed. HIV and migration are not linearly related; rather, they are linked laterally, as a result of being removed from the conventional norms and restrictions that govern social behavior. Social and sexual behaviors that raise one's risk of contracting HIV/AIDS can be brought on by a hostile and isolating atmosphere, being away from family, and not having access to resources and support networks. The degree to which an individual is susceptible to contracting HIV, spreading the infection to others, or experiencing insufficient medical attention or social support depends on a variety of preconditions of a cognitive, behavioral, and social nature. Raising awareness is just one strategy to stop HIV/AIDS. This topic falls under the social sciences as well.

4.1.4 Disease and Society

Customs, beliefs, traditions, values, and ways of living vary among cultures. People in a society can be influenced by culture in both positive and negative ways. Whether the social environment is studied directly or indirectly, culture has a big impact on how diseases arise. For example, the disease known as atherosclerosis is brought on by eating fatty foods. This disease is more common in people whose culture involves eating animal fats.

Placing the disease and the human behavior that causes it within the sociocultural context helps to clarify the dynamics surrounding the disease's transmission and the subsequent behavior changes that would be the ultimate goal of the interventions. Therefore, it would be extremely constrained and inaccurate to solely view the epidemic as a medical and health problem. It needs to be understood in terms of social and cultural dimensions. AIDS is not just a medical condition; it also has important social components. Understanding what puts some people at a higher risk of contracting HIV has been the focus of anthropological research on risk and its social context. Everybody is biologically vulnerable to acquiring HIV if they are exposed to the virus through one of its modes of transmission. It becomes critical to recognize that the transmission necessitates a specific identifiable behavior. Understanding the social, economic, political, and cultural contexts in which the behavior takes place as well as the probability of such behavior within specific groups becomes essential.

Cultural taboos also indirectly contribute to the disease. A person disregards advice about a disease in order to uphold cultural taboos. An individual's knowledge of illnesses such as gonorrhea, syphilis, and HIV/AIDS is crucial for controlling and preventing these diseases. One can prevent the spread of contagious diseases by adopting personal security measures. There is still no public discussion of the sexrelated issues. since it is thought to be offensive. However, it seems that knowledge and open communication are preventive steps to stop the spread of infectious diseases.

Organizational culture and social change can create some of the conditions that serve as catalysts or supports for the onset of disease. The nutrients are also impacted by changes in the economy. But it's not a given that someone who eats a lot of nutritious food won't get sick from these kinds of things. Social relationships within families have altered as a result of new occupational considerations and information-gathering initiatives aimed at lowering disease risk. Relief and relaxation are felt on the one hand, but tension has been created by the physical and emotional traits of children and teenagers on the other. Social change is putting pressure on the social structure. The concept of the illness is not included in this domain. Peter Conrad and Lavania contend that it is easier to draw a clear link between the illness and reason. Even now, some medical professionals do not believe that a person's lifestyle can cause a morbid condition. In cases of morbidity, the disease's immediate cause is considered to be important. But we also need to acknowledge our connection to human culture and its influences if we hope to stay disease-free for a very long time (Conrad, 1982:10-12 and Lavania, 2010: 58-65).

When these tasks are combined with HIV/AIDS, recent studies on the disease have revealed that unsafe sexual behavior is a contributing factor in 86% of cases of HIV/AIDS. HIV/AIDS-related problems that a person and his family face have an effect on social structure, either directly or indirectly. Consequently, the disease can be studied as a social fact. The socio-cultural structure of Indian society is still dominated by traditional norms and values. Sexuality-related norms are still rigorously upheld in Indian society. Indians tend to avoid having candid discussions about matters pertaining to sexuality. The majority of Indians still live in rural areas, and the nation continues to face challenges with low women's status, unemployment, poverty, superstition, and illiteracy. In a sociocultural setting like this, HIV/AIDS infections can also be caused by low literacy or education levels, as well as by not knowing how to use condoms properly.

Early on, it was thought that since risky behaviors such as homosexuality and having multiple partners were not seen as part of Indian socio-cultural norms, India would not be greatly affected by the epidemic. It was believed that the traditional sociocultural norms of mother goddess worship, universal marriage, and ensuing heterosexual

relationships, along with social prohibitions against an explicit focus on sex and sexuality in public social interactions and discourse, provided the necessary protection against a disease that was primarily transmitted through sexual activity, according to Ramasubban (1998).

Due to the dissolution of the joint family system, the rise of the nuclear family, increasing urbanization, and the movement of people from rural to urban areas, traditional family structures have evolved over time. Due to differences in gender, class, and urban/rural development rates, people are more vulnerable to biological threats like the HIV/AIDS epidemic. The people's inability to obtain the resources necessary to maintain the bare minimum of housing, food, health, and livelihood is one of their biggest issues.

Under these conditions, the disadvantaged group may often engage in profitable or commercial activities that may increase their vulnerability to health problems, including HIV infection. Service and infrastructure development are hindered by insufficient social and economic development. The culture of silence surrounding sexuality prevents people from learning about the causes, symptoms, and prevention of health epidemics. In many cases, it also prevents people from receiving medical treatment. Women in Indian society are rarely involved in decisions that impact the institution of marriage and the family because of the patriarchal nature of the country. According to an epidemiological analysis of the data, HIV infection has two main characteristics: it spreads from urban to rural areas and from groups participating in risky behavior to the general population (NACO 2001). Because it demonstrates how the infection is spreading geographically and among various population groups, this pattern gives rise to grave concerns.

Lowering the risk of infection slows the spread of HIV by emphasizing behavioral changes and enacting change in circumstances where there is a risk of infectious disease. Reducing vulnerability lowers the risk of infection and the impact of the epidemic by focusing on access to health services, sexual behavior information, life skills-based HIV/AIDS education, addressing cultural practices and stereotypes, and providing

services beyond legal and social norms to reduce stigma and discrimination. Vulnerability to HIV/IDS is decreased by focusing on improving the productive lives of those living with HIV/AIDS, lessening the stigma and poverty faced by surviving family members, increasing investment in care, education, and social support, and lessening the epidemic's impact. As a result, the community is better equipped to fight the epidemic.

In book Medical Sociology, Negal (1986), discussed the birth and development of medical sociology in India. As Indian society has evolved, so too have issues pertaining to therapy. Different people arrived at different times and brought different therapies with them to maintain their own health in Indian society. In India, the Ayurvedic method was used before the British arrived. When the British first arrived in India, they brought with them methods for treating and preventing allopathic diseases.

The Indian government has been monitoring the development of medical sociology since the decade that began in this century. Social scientists and anthropologists have received funding from the government to conduct research on public health-related topics. Numerous sociological techniques could be used to address some of the public health problems. for the reason that, in terms of medical sociology generally, India has not yet realized its full potential. On the other hand, initiatives to spread knowledge about HIV/AIDS have grown over time. A review of the literature indicates that the impact of HIV/AIDS over the past three decades has opened up new research directions for medical sociologists.

HIV/AIDS may not be treatable with medication or drugs, but it can be prevented and controlled in society with a better understanding of scientific knowledge and sociocultural structure. HIV/AIDS prevention and control are difficult in India because of the country's high rates of illiteracy, low educational attainment, strong traditionalism, and religious views on sexuality. Thus, in order to reduce the prevalence of HIV/AIDS in Indian society, NACO has concluded that it is crucial to spread scientific knowledge, with an emphasis on women's education in particular. Therefore, in societies where scientific knowledge is influential, HIV/AIDS prevention and control are made easier.

Prevention is always better than treatment, as there is currently no effective vaccine or treatment for the AIDS epidemic. One partner faithfulness, abstinence, and monogamy are common strategies to stop HIV transmission. Additional techniques include getting safe blood or blood products from blood banks, using sterile, disposable, or brand-new needles or syringes, and using condoms correctly and consistently. According to Mann M et al. (1994) propagating prevention efforts, a supportive social environment, health and social services, and education information were found to strengthen communities' and the nation's capacity to implement successful programs. These components need to be considered locally, tailored to the specific culture, and executed with the available means.

On one end of the spectrum are the "high risk groups" (HRG) or the "core group of high frequency transmitters." These comprise people who visit STD clinics, men who have sex with men (MSM), female sex workers (FSW), and drug injectors (IDU) (NACO 2009–10). These individuals are members of groups whose actions increase their risk of contracting HIV. On the other end of the continuum is the general population, which is thought to be "safe" from the epidemic because they are not engaged in high-risk activities. Studies and surveillance reports from the 1990s showed that the general population was becoming infected with HIV/AIDS at a rapid rate. These groups did not always behave in a way that was dangerous. The epidemic continued to spread to children and women. This disclosed a third category of subgroups called the "bridge population." Both male and female sex workers usually use them as partners or clients (NACO 2007). The bridge population is defined as active duty military personnel, migrant laborers, and truck drivers. Married men have frequently functioned as a conduit between HRGs and the broader public; consequently, women in relationships that they understand to be monogamous become contaminated by the knowledge that their husbands have multiple partners.

4.1.5 HIV/AIDS and Risk

Most people engage in some kind of risky activity on a daily basis, but they cease when they become aware that they are endangering themselves. There is a dearth of knowledge regarding people's interpretations of their sexual experiences and possible consequences of disease. Personal risks are perceived as being so small as to be overlooked or ignored, which can result in a range of thrilling or pleasurable activities that have the potential to be highly dangerous and damaging. Thus, it can be difficult to comprehend the rationality—or lack thereof—involved in different types of addictive behaviors. For example, smokers may be aware of the risk to others but believe they pose very little risk to themselves.

Because it is difficult for people to estimate and calculate risk based solely on factual information, people rely on "cultural heuristics" to understand how risk is perceived. When processing information, people employ heuristics—logical shortcuts—to make complex cognitive tasks simpler (Bailey, A., & Hutter, I., 2006). Heuristics that are derived from cultural meaning systems and deeply embedded in people's daily lives speed up decision-making when it comes to risk perception. The process of negotiating risks shows how people use social and cultural biases to create their reality and decide what to fear based on their lifestyle choices and accepted social and cultural norms. According to a Sub-Saharan African study, older men looking for women who are HIVpositive don't seem to consider the possibility that they could be infected as a viable or even acceptable risk when it comes to identity construction. But risk usually refers to personal risk, which means that it has more to do with personal accountability, decisionmaking, and blame than it does with societal accountability. Tsasis, P., and Nirupama, N. (2008) state that risk perception in the context of HIV/AIDS is influenced by an individual's inclination to be risk-averse or risk-seeking as well as their understanding of the particular situation. Because risks are unpredictable and access and knowledge are not distributed equally in societies, people are not always in a position to define and comprehend risk. Stated differently, individuals may lack the opportunity or capacity to determine the extent to which they are affected by the risk. Different risk

perceptions are linked to different threats because different stakeholders and groups have competing interests at the public discourse level. It is therefore possible to affect how individuals perceive risk in both social structures and institutions.

Therefore, a deeper understanding of how people form their perceptions of risk requires an understanding of the relationship between social networks and risk perception. We can then use this knowledge to better understand how to influence people's behavior in order to slow the spread of HIV. People's behavior will change according to their comprehension of the behavior and how they feel about it. An individual's health behavior is influenced by how they perceive their actions. A person's beliefs about their perceived vulnerability to health issues, the severity of the illness, the efficacy of the new behavior, the benefits of taking preventive action, and the challenges of behavior modification will all influence how they behave. Knowledge and attitudes regarding health behavior are crucial for both understanding health practices and encouraging behavioral changes for improved health-seeking behaviors.

Social scientists have conducted numerous studies on the connection between HIV infection and human behavior. These studies have focused on risk behavior, or behaviors that are innate to human nature and raise the risk of infection. This alternative perspective allowed intervention efforts to shift from focusing on particular groups of people to focusing on specific behavior patterns. Barnett T. & Kadiyalal (2004) assert that the concept of risk evolved to be seen as a threat that "they" pose to "us," blatantly ignoring the fact that the behavior's riskiness is a feature of the environment rather than of particular individuals or practices, in order to support such an understanding of the epidemic. It's been said that discussing "risk categories" conveys the idea that the illness is someone else's. AIDS is not spread by high-risk "categories," but rather by high-risk behaviors like the exchange of bodily fluids.

4.1.6 HIV/AIDS Awareness Programs in Gujarat

In late 1985, the World Health Organization (WHO) started creating the Global Strategy for the prevention and control of AIDS in response to the consequences of HIV

infection and the rise of AIDS. The first WHO anti-AIDS initiative was based on this strategy, which was thoroughly reviewed and discussed in 1986. Preventing HIV infection, reducing the social and personal effects of HIV infection, and coordinating national and international efforts to combat AIDS are the three main objectives of the Global AIDS Strategy (Rao D., 2000, pp. 207–208). India's response to the risks of HIV/AIDS is based on the global strategy proposed by the WHO.

HIV/AIDS is a major health concern in India. The people's social standing and quality of life have been impacted. India saw its first cases of AIDS in the mid-1980s (Pais, 1996). Since then, it appears that HIV infection has been spreading quickly in a number of places (NACO, 2001). The first HIV case was reported in Tamil Nadu, India, in 1986. Infection rates rose and defenses got stronger during the 1990s. The government created the NACO in 1992 in an effort to curb the spread of HIV and AIDS throughout the country. That same year, the government unveiled the National AIDS Control Program (NACP), a strategic plan for HIV prevention. This plan established State AIDS Control Societies (SACS) and provided administrative and technical program management in 25 states and 7 union territories. State AIDS Control Societies achieved several noteworthy strides in HIV prevention, especially in the area of blood safety (NACO 2007). In fact, India's fight against HIV/AIDS has shifted its focus to prevention and education since the early 1990s (NACO 2010, Ramasubban 1998).

Following the discovery of the first HIV infection in 1986, the Indian government initiated programs for prevention and awareness-building under the first and second Medium Term Plans (NACP-1, 1992–1999), respectively. Phase 1 only addressed blood safety. The Blood Safety Program's primary goal was to guarantee that there was enough safe blood available throughout the state of Gujarat. It's possible that the Blood Safety Program wasn't enough to stop and manage HIV/AIDS. Phase 2 of the National AIDS Control Programme (NACP) aimed to decrease HIV transmission through behavioral modification and strengthen India's ability to combat the infection. But as the epidemic's complexity has grown, so too have the NACP's approaches and policy frameworks. Here, the focus has moved from changing behavior to increasing awareness, from a small

number of NGOs to an increasing number of networks of people living with HIV/AIDS, and from a centralized national response to a decentralized response.

Using the knowledge gained from Phases 1 and 2, India developed the Third National AIDS Programme (2007–2012). Over the next five years, NACP-3's primary goal was to integrate prevention, care, support, and treatment programs in order to halt and reverse the epidemic in India. To achieve the aforementioned goals, NACP-3 uses the following four strategies: 1. Preventing new infections in high-risk populations and the general public by: Expanding the use of targeted interventions (TIs) in high-risk groups; and stepping up interventions in the general public. 2. Offering more care, assistance, and therapy to a greater number of HIV/AIDS patients, 3. For prevention, care, support, and treatment programs, strengthening the systems, infrastructure, and human resources at the district, state, and federal levels; and 4. fortifying a Strategic Information Management System that spans the entire country.

It suggests that people outside of these groups are not concerned about HIV by concentrating on high-risk groups. Consequently, individuals who do not belong to high-risk groups (HRGs) often have their vulnerability disregarded (Craddock et al. 2004). To prevent and control HIV/AIDS, everyone in the community needs to be aware of the epidemic.

Individuals who would normally regard themselves as low risk often have an illusion of security and think they will never become infected with HIV. They frequently neglect testing as a result, unintentionally exposing themselves to the virus. Studies (like IIPS and ORC Macro 2008) indicate that the HIV/AIDS epidemic is not well known among low-risk populations. Furthermore, because the general public is unaware of the virus's modes of transmission and available defenses, it spreads swiftly among them once a member of a low-risk group contracts the infection. Thus, educating people about HIV transmission and prevention should help stop the virus from spreading among healthy people (Vandemoortele and Delamonica 2002). Accordingly, prevention efforts should

not only focus on populations with low risk of HIV infection but also attempt to lower the risk of HIV diffusion in the general population (Craddock et al. 2004).

Given that over 400 languages are spoken throughout India, HIV/AIDS education and prevention are difficult. This suggests that while national efforts can be made to prevent and educate people about HIV/AIDS, state and local initiatives are often the most effective. India's vastness makes it difficult to evaluate the overall efficacy of HIV/AIDS prevention. A more comprehensive understanding of the crisis can be obtained by looking at each Indian state separately because most of them have larger populations than most African countries. In India, regional programs are carried out in collaboration with NACO by the state-level AIDS Prevention and Control Societies. Funding for youth outreach programs, blood safety checks, and HIV testing was given to state AIDS control societies under the second phase of the government's National AIDS Control Program (NACP-2), which ended in March 2006. Concurrently, the epidemic was brought to light through radio plays, TV commercials featuring a well-known Indian actor, concerts, and a day dedicated to voluntary blood donation. Schools provided HIV education to the youth. Active learning activities, such as debates and roleplaying, were used to teach students about AIDS, and peer educators and teachers received training in the subject (NACO 2009).

The State AIDS Cell (SAC) for the Prevention and Control of HIV in the State was founded in December 1992 to implement phase 1 of the National AIDS Control Program. The State AIDS Cell implemented the program in compliance with NACO guidelines and with the approval of the State Empowered Committee, which was established at the state level for that specific purpose. The State AIDS Empowered Committee made the decision to incorporate NGOs and to quickly and effectively implement the program through inter-sectoral coordination for AIDS prevention by registering the State AIDS Cell as a registered society. The Indian government has recommended that the State AIDS Control Society be formed for the program's second phase, which begins in April 1999. The National AIDS Control Program has been implemented since then by the State AIDS Control Society.

It is clear that this illness does not currently have a treatment. Preventing HIV infection is one of the most important strategies to decrease the effects of this health problem. Education is a crucial tactic for putting an end to this epidemic. People should have greater access to information about AIDS, STD (Sexual Transmitted Disease) treatment, and the illness's effects in order to stop it from spreading. There are times when the general public, medical professionals, friends, and even family mistreat people who are HIV positive. This frequently leads to personal suffering, which decreases the likelihood that people will take the necessary steps to seek treatment and care. If people's knowledge, attitudes, and behaviors regarding HIV/AIDS are assessed, we will be able to better understand people's current level of awareness. The ability to control the spread of disease through appropriate intervention will be highly advantageous for planners, health professionals, and researchers. The assessment would also be helpful in creating health programs that are customized to the demands of various communities' lifestyles. It will enhance peoples' health and act as a spur for the country's general development (James, 2010).

Rules pertaining to testing, informed consent, and privacy have been established by the NACO. The statement claims that in addition to biological considerations, HIV testing also takes human, ethical, and legal factors into account. NACO actually lacks the necessary framework to enforce these regulations. A legal framework and appropriate oversight are necessary to address the disintegration of laws and codes. It would remain difficult to put this philosophy into practice unless and until a system for monitoring the improper conduct of NGOs and medical professionals is created. Secrecy is crucial for HIV patients due to the extreme stigma associated with living with HIV/AIDS (Sharma, 2010).

Numerous initiatives are carried out by the Gujarat State Government to control and prevent HIV/AIDS in Gujarat. These programs followed NACO guidelines to the letter. Among these programs are: 1. ICTC, 2. Targeted Intervention (TI), 3. STI Care Services, 4. Blood Safety Programme, 5. Information, Education & Communication, 6. Red Ribbon Club Programme, 7. Health Education and Lifeskill Programme (HELP), 8.

Link Worker Scheme (LWS), 9. Care, Support and Treatment, ART Centre and LAC, 10. Community Care Centres (CCC) etc. and 11. Strategic Information Management Unit (SIMU).

4.1.7 Strategies of GSACS in Gujarat

Without an understanding of the biological and medical sciences, we are unable to fully comprehend HIV/AIDS. Since the world learned about the epidemic, people living with HIV/AIDS have faced social reactions from ignorant people that include fear, discrimination, and shame. HIV/AIDS has a reputation for being stigmatizing and discriminatory. Consequently, people with HIV/AIDS have been socially rejected by family, friends, and society at large.

The "State AIDS Cell" was founded by the Gujarati government in 1992 in an effort to stop the pandemic's spread. Industrialization and urbanization are two distinct aspects of the state. It leads to migration, which increased the rate of HIV/AIDS infection in the community. The first case of HIV/AIDS was identified in Gujarat state in 1986. The Health and Family Welfare Department (HFWD) of Gujarat state received guidance for the formation of the GSACS from the NACO, which oversaw the implementation of the AIDS Control Programme Phase 3. It seeks to provide integrated services in partnership, such as HIV/AIDS prevention, healthcare, and treatment. The cooperation of private organizations, educational, research, and training institutions, citizen associations, and HIV/AIDS patient groups has made these services possible. The GSACS's multifaceted strategy, activities, and accomplishments for HIV/AIDS prevention and control are listed below:

4.1.7.1 Integrated Counselling and Testing Services

In a discreet, encouraging environment, people can accept and learn about their HIV sero-status at the Vatsyayan Kendra & Mamta Clinic (VKMC). VKMC-ICTC is now an essential part of HIV prevention programs since it is a reasonably cheap intervention to prevent HIV transmission. As of the end of March 2014, Gujarat had 1621 ICTCs (Integrating Counselling and Testing Centers), comprising 309 mobile ICTCs,

1309 facility-ICTCs (Private Partnership - PPP model, PHCs, CHCs, and Sub Center), and 309 stand-alone ICTCs. A total of 941582 general clients and 778639 pregnant women received testing and counseling at the ICTC in March 2014; 12282 of these people tested positive in the 2011–12 period. Seventeen pregnant women were identified as HIV positive out of the 11,282 individuals who underwent testing. In order to prevent the spread of HIV from mother to child, 681 mother-baby pairs received prophylaxis with nevirapine in the 785 live births.

At an ICTC, an individual may choose to receive HIV counseling and testing on his own initiative or at the advice of a medical professional. The principal duties of an ICTC are as follows: 1. Early identification of HIV infection; 2. Provision of basic information on HIV/AIDS prevention and modes of transmission to promote behavioral modification and reduce susceptibility; and 3. Facilitation of access to additional HIV prevention, care, and treatment resources.

Every demographic group should be served by a single ICTC at a healthcare facility. Nonetheless, an ICTC can be found in locations that serve specific demographics, such as expectant mothers. Because pregnant women make up the majority of clients who use the counseling and testing services provided by an ICTC, one can find one in a district hospital, maternity home, or the obstetrics and gynecology department of a medical college. The creation of such a facility is justified by the requirement for prophylaxis to prevent the transmission of HIV from infected pregnant women to their unborn children. In a similar vein, an ICTC may be housed in a tuberculosis microscopy facility or tuberculosis sanatorium where the majority of visitors are tuberculosis patients.

It is not necessary for an ICTC to evaluate and counsel every member of the public. Subpopulations that behave in a high-risk manner or are more susceptible exist. Generally speaking, these subpopulations have greater rates of HIV prevalence than the overall population. To identify populations that are vulnerable or at risk and ensure that they have access to HIV counseling and testing services, ICTC staff members must collaborate. Physicians who see patients who exhibit symptoms suggestive of HIV/AIDS

or who have a history of risky behavior can also refer them to an ICTC for testing and counseling.

The Employees' State Insurance Department (ESID), railroads, governmentowned healthcare facilities, nonprofit and public sectors, and locations where nongovernmental organizations (NGOs) operate are all potential places to find an ICTC. In the medical facility, the ICTC should collaborate effectively with the departments of medicine, microbiology, obstetrics and gynecology, pediatrics, psychiatry, dermatology, preventive, and social medicine, among others. Given the comparatively low cost of the HIV test and the general perception of low risk, traveling a considerable distance for testing could serve as a strong disincentive. Therefore, it's imperative to ensure that testing and counseling centers are located as close to the populace as feasible. The area where vulnerable and at-risk populations have the greatest access is the best choice for ICTCs. A few prerequisites for creating an ICTC are the government health sector, the private/not-for-profit sector, and non-governmental organizations. Although ICTCs can take many different forms, two main categories can be identified: fixed-facility ICTCs and mobile ICTCs. The three professionals that the ICTC needs on its skilled team are the manager (medical officer), the counselor, and the lab technician. An outreach worker would be necessary in districts where there is a high prevalence.

A private discussion between a client and a counsellor with the aim of educating the client about the disease and changing their behavior is known as HIV/AIDS counseling or education. It also seeks to assist the client in understanding the consequences of their decision and deciding whether to get tested for HIV. The steps in HIV counseling are HIV post-test counseling, HIV pre-test counseling, and HIV information. Basic HIV/AIDS education and risk assessment are provided to walk-in clients as part of HIV pre-test counseling and information. During HIV post-test counseling, the client is helped to comprehend and cope with the test results.

If the test results are negative, the counselor helps the client adopt behaviors that reduce their risk of HIV infection in the future and goes over basic HIV information with

them. If the client is within the window of opportunity, a repeat test is recommended. The closest microscopy facility is directed to clients who may have tuberculosis. In the event that the test is positive, the counselor offers support for coping and assists the client in understanding the implications of the result. The counselor guarantees access to care and treatment and supports sharing the spouse's HIV status. The significance of embracing safe behaviors to prevent the HIV infection from spreading to others is underlined once more in follow-up counseling. Follow-up counseling also includes establishing links and making recommendations to care and support services, including ART, nutrition, in-home care, and legal assistance.

This is the most common and direct method of diagnosing HIV infection based on the identification of HIV antibodies generated in the blood of an HIV-positive individual. Rapid test methods are widely used to identify HIV infection. They can provide the customer with fast results and are easy to use. There are numerous quick tests that apply diverse principles. Rapid HIV test kits are recommended by the NACO for use in ICTCs because the client receives results in 30 minutes after the test. Rapid test kits that identify more than 99.5% of all HIV-positive individuals and yield falsepositive results in less than 2% of test subjects are recommended for use in an ICTC. Every client will receive free testing from all ICTCs in the government health sector as well as all "stand-alone" ICTCs funded by the NACO/SACS. If a single test yields a negative result, the client is considered HIV-negative. The client is considered HIVpositive if the same blood sample is tested three times using different kits that use different antigens or principles and the results are all positive. Rapid test kits that identify more than 99.5% of all HIV-positive individuals and yield false-positive results in less than 2% of test subjects are recommended for use in an ICTC. Every client will receive free testing from all ICTCs in the government health sector as well as all "standalone" ICTCs funded by the NACO/SACS. If a single test yields a negative result, the client is considered HIV-negative. The client is considered HIV-positive if the same blood sample is tested three times using different kits that use different antigens or principles and the results are all positive.

4.1.7.1.1 HIV Testing and the Window Period

The time interval (6–12 weeks) between the onset of HIV infection and the detection of HIV antibodies in the blood is known as the "window period." Blood drawn during the window period may test negative for HIV antibodies. In certain cases, further testing may be necessary after a 12-week period.

4.1.7.1.2 Emergency Testing

For laboring women who are HIV-unknown, the medical officer, resident physician, or labor room nurse can offer basic information about HIV/AIDS and HIV testing (NACO, 2005). Following that, a single HIV test will be given to ascertain the pregnant woman's status and determine whether starting antiretroviral therapy (ARV) is necessary to prevent HIV transmission from mother to child. The next working day, the ICTC Lab Technician will gather and examine a second sample to verify the existence of HIV. Sometimes the patient is unable to travel to the ICTC, so the blood sample is sent from another department or the hospital ward. In this case, the ICTC must ensure that the patient has received adequate medical advice and that a requisition slip was delivered with the blood sample. Post-test counseling will be provided by the ICTC counselor assigned to the patient's ward or department upon admission.

Testing for HIV is done in a different way than testing for other illnesses. The required counseling must be provided prior to pretesting and the reporting of HIV testing. HIV testing facilities are required by the Guidelines on HIV Testing (2007) to provide clients with counseling prior to and during the test, in addition to maintaining strict confidentiality. The results of their HIV tests are shared with the clients by the counselors. The facility acts as the first hub for HIV treatment and management. A total of 1621 ICTCs for integrated HIV/AIDS counseling and testing have been set up in the state of Gujarat. In Gujarat, free HIV/AIDS testing and counseling are provided by community health centers, nonprofit hospitals, district hospitals, municipal hospitals, and medical colleges.

4.1.7.2 Targeted Intervention

There has been a recent trend in the HIV/AIDS epidemic suggesting that it is also affecting the general population. Owing to these reasons, the main strategy for targeted intervention (TI) is the saturation of high risk groups (HRG) throughout the state. Targeted intervention efforts have been GSACS's primary method of halting the HIV/AIDS virus's transmission. Bridge populations, such as truck drivers and single male migrants (SMM), as well as high-risk groups, such as transgender individuals (TG), female sex workers (FSW), and men having sex with men (MSM), are the main targets of various preventive interventions. The primary driving forces behind the focused intervention efforts have been CBOs and NGOs.

4.1.7.3 Sexually Transmitted Infection Care (STI) Services

The goal of syndromic case management, private physicians' involvement in publicprivate partnership initiatives, and STI/RTI treatment facilities is to reduce the incidence of STIs. There are sixty active STI clinics spread across medical colleges, district hospitals, trust hospitals, and some sub-district hospitals. Coordinators have been assigned to each of these clinics to ensure appropriate STI counseling.

4.1.7.4 Blood Safety Programme

The main goal of blood safety programs is to ensure that there is an adequate supply of safe blood available throughout Gujarat. Gujarat has 143 operational blood banks in its network, which guarantees that blood is always available. The focus must be on promoting voluntary, repeat blood donation in order to lower the risk of complications from blood transfusions and other blood transfusion-related illnesses. Unsafe blood and its products are the cause of the HIV virus transition in 2% of all cases.

The availability of safe blood and its products is a concern for the NACP. The program's position is that enhancing the state's ability to exchange blood, assisting with testing each blood unit of voluntary blood banks, and pretesting exchanged blood for HIV in order to ensure safe blood are essential elements. To guarantee the safety of the blood,

the GSACS has partnered with the Indian Red Cross Society and Charitable Blood Bank to exclusively provide testing kits out of Gujarat's 64 blood banks. As stated in the Annual Report 2013–14 (GSACS, 2015), the primary objective of this program is to make safe blood available to all those in need at the right time. This has been made feasible by a network that includes 139 Blood Banks. 632463 units (79.6%) of the 794056 units (98.3% achievement) were acquired through voluntary blood donation, compared to the target of 807880 units. There is a 0.05% sero-positivity rate, and the total number of separated components is 447760 units (56.4%).

4.1.7.5. Voluntary Blood Donation

The collection of healthy blood is the main objective of voluntary blood donation. The priceless gift of voluntary blood donation is available to both wealthy and underprivileged donors. Every healthy individual has the capacity to donate blood on a quarterly basis. The promotion of voluntary blood donation has progressed thanks to the government and an optional blood bank. Individuals with more education are passionate about volunteering their blood. In college, student organizations and the National Service Scheme (NSS) are usually the means by which students donate blood. Some people lack the motivation to give blood. Most students stop being interested in giving blood after finishing the study.

4.1.7.6. Information, Education and Communication

In addition to offering information, education, and communication to the general public, the state's primary tactics for the vulnerable population are mainstreaming and behavior change communication, or BCC. Gujarat has arranged several IEC events to promote HIV/AIDS prevention and control, such as the printing and distribution of pamphlets, posters, flip charts, and statements for the mass and mid-media. The belief held by authorities is that HIV/AIDS can be contained through vigorous public awareness campaigns that target key demographics such as women, youth, and migrants. Meetings, conversations in groups, and initiatives that advance people's awareness, sensitivity, and advocacy are just a few of the activities that make use of information, education, and

communication (IEC). Among the IEC programs Gujarat state has been running are the Integrated Rural HIV/AIDS Program, Jivandeep Project, essay and catechism competitions, Red Ribbon Club, volunteer program, and proficiency education course. For a brief while, the IEC program has only been available on particular days. It does not fully address the need for HIV/AIDS education among the general public. IEC programs should be regularly offered to a range of social groups.

4.1.7.7. The Red Ribbon Club Programme

The Red Ribbon Clubs aim to improve access to safe and sufficient blood supplies for all those in need, foster healthy lifestyles, and instill in all students in educational institutions the values of service through regular voluntary blood donation. This program addresses important health issues such as drug addiction, stress-free environments, voluntary blood donation, HIV/AIDS, healthy eating habits, and reproductive and sexual health, including RTI/STI and HIV/AIDS.

4.1.7.8. The Health Education and Life-Skill Programme (HELP)

The Health Education and Life-skills Program (HELP) was approved by the State Coordination Committee (SCC), which is chaired by the Principal Secretary (Education), Government of Gujarat. The program's main objective is to promote the holistic development of adolescents while keeping health at its center. The Gujarat Council of Educational Research and Training (GCERT) is the program's Nodal Agency. A comprehensive HELP module has already been developed for teachers.

4.1.7.9 The Link Worker Scheme (LWS)

To address the following issues, the program is building a network of trained local staff members who will serve as Link Workers and volunteers: a. reach out to HRGs and vulnerable young people (men and women) in rural areas; b. reduce stigma and discrimination by working with already-existing community structures/groups, such as Village Health Committees, Self Help Groups (SHG), etc. c. draw links between HIV, gender, and sexual orientation and emphasize factors that increase the vulnerability of women and young people in both HRGs and the broader community, Encourage the

regular and increased use of condoms as a means of preventing STIs and unplanned births. e. Promote the use of prevention, care, and support services and programs—especially those pertaining to STIs, ICTC, PPTCT, ART, and other health services—and raise public awareness of them. f. Make it easier for youth-friendly health and counseling services to be provided via the public health system's current service delivery channels. g. Assist HRGs in reintegrating into the community. Eleven districts in Gujarat are implementing the LWS: Dahod, Surendranagar, Navsari, Banaskantha, Mehsana, Ahmedabad, Rajkot, and Bhavnagar (funded by Global Fund Round 7) and Valsad, Surat, and Vadodara (funded by UNICEF).

4.1.7.10. Care, Support and Treatment

In Gujarat's 26 districts—six of which are Category A districts and four of which are Category B districts—there are an estimated 1,37,000 People Living with HIV/AIDS (PLHAs), whose ages range from 15 to 49. There was just one ART center in 2005, and it was situated at Ahmedabad's B.J. Medical College. It provided care for 1303 PLHAs.

4.1.7.10.1 The ART (Anti-Retro Viral Therapy) Centre

According to the Annual Report 2013-14 (GSACS, 2015) in Gujarat as on March 2014 there are 27[86] fully functional ART Centres, with a total of 79132 patients registered in HIV care at ART Centres, 52729 patients started on ART & a total of 39070 patients alive on ART. The state average for LFU of on ART patients is 3412. As on March-2014, 39070 PLHA are dependent on ART in Gujarat. Out of these 4093 are being treated in the BJMC Ahmedabad, 3908 in the NCH Surat, 2724 at the SMIMER

[86](1)B.J.Medical College, Ahmedabad, (2) New Civil Hospital, Surat, (3) PDU Hospital, Rajkot, (4) Sir T. Hospital, Bhavnagar, (5) General Hospital, Mahesana, (6) Reliance Industries Hazira, Surat, (7) SSG Medical College & Hospital, Vadodara, (8) Mahatma Gandhi Hospital, Surendranagar, (9) GG Hospital, Jamnagar, (10) General Hospital, Junagadh, (11) G.K. General Hospital, Bhuj, (12) SMIMER Hospital, Surat, (13) General Hospital, Palanpur, (14) V.S. Hospital, Ahmedabad, (15) Sir Pratap General Hospital, Himmatnagar, (16) General Hospital, Navsari, (17) General Hospital, Amreli, (18) General Hospital, Patan, (19) General Hospital, Porbandar, (20) General Hospital, Godhara, (21) General Hospital, Bharuch, (22) General Hospital, Valsad, (23) General Hospital, Dahod, (24) General Hospital, Nadiad, (25) General Hospital, Gandhinagar, (26) Sola Civil Hospital, Ahmedabad, (27) Vyara Civil Hospital, Tapi.

Surat, 847 at the Reliance Surat, 1776 at V.S. Ahmedabad, 3485 in Rajkot, 1981 in Bhavnagar, 1529 in Mahesana, 2776 in Vadodara, 1111 in Surendranagar, 1063 in Jamnagar, 829 in Amreli, 1444 in Palanpur, 850 in Patan, 422 in Porbandar, 887 in Navsari, 1459 in Junagadh, 494 in Godhra, 1289 in Himatnagar, 1185 in Bhuj, 1508 in Nadiad, 521 in Dahod ART, 691 in Bharuch, 1179 in Valsad, 226 at Sola Ahmedabad, 168 at vyara ART centre and 625 in Gandhinagar. Nearly five Hundred new patients are put on ART every month in the State.

4.1.7.10.2 The Link ART Centre (LAC)

ART at the Taluka Level is provided by the Link ART Centers, which are situated nearer to the patient's residence. 40 LACs were operational in Gujarat at the end of March 2012. People who test positive for HIV can lead long, healthy lives before developing the symptoms of AIDS. The last stage of the HIV virus's evolution is AIDS. It is controlled by ART, which increases an individual's defenses against its attacks. Naturally, not all HIV-positive people require it. 10% of HIV-positive individuals need to be on antiretroviral therapy (ART), which prolongs healthy life.

In Gujarat state, the first ART facility opened its doors in 2005. Subsequently, free treatment for HIV-positive individuals was established in the districts of Ahmedabad, Surat, Vadodara, Rajkot, and Bhavnagar. To guarantee that everyone could use the service, Gujarat is the only state that established the five link centers in the aforementioned five districts.

4.1.7.11 Suraksha Clinic (STD/STI Clinic)

By the end of March 2014, GSACS had provided support to 63 designated STI/RTI clinics at District hospitals, PHCs, and CHCs, as well as 135 STI Clinics in Targeted Interventions. Until the end of March 2014, patients had 119135 STI/RTI episodes managed, compared to the annual target of 234590 episodes. A greater number of clients are now covered by the STI program as a result of our year-round extension of STI facilities up to the CHC and PHC level. The availability of STI services is being increased through targeted intervention projects.

4.1.7.12 Strategic information management unit (SIMU)

SIMU Evidence-based planning has been identified as the key to halting and reversing the HIV epidemic under the National AIDS Control Program-3 (NACP-3). The state has created a Strategic Information Management Unit (SIMU) to utilize all available information and carry out evidence-based planning. All information sources are integrated by SIMU, which then delivers strategic, logical data that can be utilized in decision-making. The outcomes of SIMU's efforts in the domains of research, strategic planning, monitoring and evaluation, and surveillance assist GSACS in tracking the outbreak and the effectiveness of its response, as well as in determining how well GSACS and its partner organizations are contributing to the achievement of predetermined objectives.

4.1.7.13 Launch of Strategic Information Management System

During the implementation of NACP-3, it was felt that the data from the HIV Sentinel Surveillance and Computerized Management Information System (CMIS) are not sensitive enough to detect the emerging hot spots of the epidemic because the data entry is done offline. In order to tackle this issue, NACO has established the Strategic Information Management System (SIMS), an internet-based platform that centers on strategic planning, oversight, assessment, observation, and investigation at both the federal and state levels. Effective tracking and response to the HIV epidemic are the main objectives. The responsibilities of each program officer are made clearer by this system, which also facilitates data flow and feedback at various levels. Every level in SIMS that permits online data entry will also increase the data's accessibility. It will be extremely helpful for future HIV/AIDS prevention strategies.

4.1.7.14 Jivandeep Project

The Jivandeep Project aims to help individuals living with HIV/AIDS become more integrated into society as a whole. It attempts to establish a safe and encouraging environment for people living with HIV/AIDS at the state and district levels. in order to combat pervasive HIV/AIDS-related misconceptions, stigma, discrimination, and silent

behavior. The main goal of the project is to expedite the program for HIV/AIDS control by involving persons living with the virus in advocacy, networking, and positive prevention. Every district in Gujarat has been involved in the Jivandeep Project. Among its primary activities are advocacy, delicate events, networking, Positive Speaker Bauru, counseling, and HIV/AIDS-related advice.

4.1.7.15 Mamta Clinic

Children under 15 who have grown up with HIV/AIDS through parental transmission. The risk of HIV transmission from mother to child is estimated to be between 30 and 40 percent; however, the risk can be reduced by nearly 7 percent by giving nevirapine to both the mother and the child during delivery. Mothers living with HIV have also advocated for HIV testing and prevention. Resources in the program can be used to locate and follow up with mothers who test positive for HIV. It has been ensured that the dosage of nevirapine for children and clinic delivery will not transmit HIV to unborn children. Mamta centers are designed to stop the HIV virus from spreading from mother to child. Mamta centers are run by medical colleges, district hospitals, municipal hospitals, nonprofit hospitals, and community health centers. These facilities provide developing children with a dose of nevirapine, a variety of prenatal tests, and free prenatal counseling.

4.1.7.16 Awareness Movement for Women

HIV infection is very common in women. Due to factors such as their biological makeup, lower social status, and ignorance of HIV/AIDS, women are more likely than men to get HIV. Forty percent of individuals living with HIV are female. In order to decrease the risk for women, the "National AIDS Control Society" has implemented a number of initiatives. In honor of "World Women Day," "Tejswini Week" has been observed throughout the state to support and increase awareness of women. Tejswini seeks to develop an immune system that combats the HIV virus.

4.1.7.17 Drop-in Centre

Social tension and psychological stress are common among HIV-positive individuals. There should be a few places they can go to feel safe and receive guidance. People living with HIV can express their emotions and provide support to one another at "Drop In Centers." The Centers were established under the National Aids Control Initiative. Most "Drop-in Centers" have been administered by individuals living with HIV/AIDS. A few of the largest cities in the state of Gujarat now have "Drop-in Centers" established. In 20 districts, the Jivandeep Project has also established comparable structures. The Gujarat State AIDS Control Society is a state-level organization that established the district-level "Gujarat State Network of Positive People."

4.1.7.18 The World AIDS Day

On December 1, we observe World AIDS Day. In order to demonstrate their steadfast commitment to the fight against HIV/AIDS, social workers, organizers, and legislators unite for a range of awareness-raising events on the day. There will be workshops, competitions, rallies, and demonstrations on this day. Students from high schools and colleges, as well as associations with health and medical authority and affiliated associations and a positive network of people, have all enthusiastically participated.

4.1.7.19 Introduction to Gujarat State Network of People Living with HIV/AIDS (G.S.N.P+)

The Gujarat State Network of People Living with HIV/AIDS is a powerful and inspiring state-level organization that is contributing to the prevention and treatment of the illness. HIV-positive people have contributed significantly to the fight against national HIV/AIDS resistance. The Gujarat State Network of People Living with AIDS was established on February 6, 2003, by seven HIV-positive people who wanted to raise awareness of their problems and types of discrimination. The goal of G.S.N.P.+ is to create a supportive and powerful environment where people living with HIV/AIDS can

live, get the care they need without facing prejudice or stigma, and continue to be socially safe. At the district level, the 24 districts of Gujarat State are home to the G.S.N.P. plus.

The "Jatan Project" is being carried out by the 18 districts of Gujarat State. Its aim is to persuade HIV-positive individuals to have their children tested for the virus. Children who test positive for HIV receive attention, medical care, and antiretroviral therapy (ART). They also try to identify and address the problems that children who are HIV-positive and infected people face. The main functions of this organization are to provide special child care for HIV-positive orphans, Rs. 500 under the medical assistant scheme, a marriage bureau for HIV-positive individuals, educational support, grain assistance to the impoverished, counseling, organizing awareness programs, and a host of other services in partnership with governmental and nongovernmental organizations.

4.1.7.20 Government schemes for HIV positive people

- A 500-rupee monthly food subsidy for OBC and SEBC people living with HIV.
- HIV-positive widows with BPL ration cards are eligible for monthly assistance of Rs. 500, plus an extra Rs. 80 for each child under the age of 18.
- Adding BPL ration cards holders who are HIV-positive to the Antyodaya Scheme.
- Rs. 100 in cash, a transportation allowance for parents of HIV-positive children, and a transportation allowance for HIV-positive individuals traveling to ART clinics.
- Annually, the Social Welfare Department provides scholarships to HIV-positive and HIV-infected students valued at Rs. 27.42 lacs.
- For orphaned children who test positive for HIV, the Social Welfare Department established orphanages in Gandhinagar and Surat.
- Special plans have been made for students to visit A.R.T. centers and receive medical attention during their time off.
- As part of the new program to assist parents of orphaned children, a monthly payment of Rs. 1000.

- As part of the Jivandeep project, individuals living with HIV/AIDS have been working to increase public awareness of the virus.

HIV-positive SEBC and OBC individuals receive 500 rupees a month in food assistance from the government. Nevertheless, people's bank accounts aren't regularly credited with this help on a monthly basis. In addition, HIV-positive people do not have enough money to purchase wholesome food. HIV-positive people and their families should receive more assistance from the government.

4.1.7.21 Organization Adhar

The Adhar organization is run by HIV positive individuals. 2004 saw its founding. The Arabic word "adhar" means "support" or "shelter." In keeping with their name, Adhar members have shown affection and support for one another. The Adhar organization started out with just ten members and has since expanded to seventeen hundred. It was founded in 2005 as a charitable trust with the goal of promoting equality for all people and combating discrimination against HIV positive people. The Adhar organization is overseen by the AIDS Control Society, which is funded by the Ahmadabad Municipal Corporation, the Project Director, and physicians from civil hospitals. Since no one can live in isolation, the organization benefits from this concept. Each and every person is respected and cared for as a member of the Adhar family. She or he consequently assimilates into society's physical and social milieu. By promoting good behavior, the Adhar organization gives its members more power. The principal objective of the organization is to cultivate an atmosphere wherein individuals living with HIV can surmount their financial, social, and psychological challenges with the assistance of the community.

in order for them to live in harmony and have their human rights respected. They've planned a range of tasks with preset objectives. It aims to strengthen with a positive outlook on life through the organization of HIV/AIDS positive individuals. It seeks to empower them to take care of their physical, mental, and emotional needs; to establish educational support for the benefit of their children; to make them socially and

economically acceptable; and to involve HIV-positive individuals in the processes of decision-making and execution.

4.1.7.22 Organization of people living with HIV/AIDS in Ahmedabad district

The Ahmedabad District Network of Positive People (ABAD N.P.+), a group of the district's HIV/AIDS-positive citizens, is supported by the GSACS. The group known as ABAD N.P.+ is made up of HIV-positive rural and urban residents of the Ahmedabad district. The "Kaira Social Service society" is the other Christian-focused organization. A few other businesses are involved in this industry.

The acronym for Ahmedabad Network of Positive People is ABAD N.P.+. It was established on May 5, 2005, and it is presently based in the district of Ahmedabad. HIV-positive residents of Ahmedabad's villages and cities make up the group that the GSACS supports. The organization's goals are to stop the spread of HIV/AIDS, assist people living with HIV in leading healthy, long lives, and to lessen their problems by doing away with stigma and discrimination.

One of ABAD N.P.+'s primary projects is to help HIV-positive people who are traveling to the A.R.T. center to receive medication as part of the Jatan Project with transportation. (b) Give groceries from the Antyodaya Scheme to a family of HIVpositive individuals who are impoverished. (c) Give HIV-positive people who are socially excluded Rs. 500 a month for nourishing food. (d) Provide HIV-positive widows living in poverty with a monthly allowance of Rs. 500 and Rs. 80 for each of their offspring. (e) Provide scholarships to HIV-positive students. (f) Students who test positive for HIV are eligible for special leave from the education department. (g) Orphans in Gandhinagar and Surat can receive care from orphanages following the death of their HIV-positive parents. (h) Under the Guardian scheme, provide a monthly assistance payment of Rs. 1000 to the guardian of an HIV-positive orphaned child. (i) The organization works to protect people living with HIV/AIDS from obstacles, stigma, and discrimination in accordance with the guarantee of human rights.

4.1.7.23 The Kaira Social Service Society

Without regard to a person's race, religion, sex, or caste, the Kaira Social Service Society has been giving special benefits and human rights to underprivileged and in needy people since 1974. The organization was driven by the principles of social work theory, which include creating social justice, establishing human kindness, eradicating poverty, and promoting peace in society. The group fights HIV/AIDS, empowers women, manages disasters, teaches kids, farms, protects girls from harm, and advances social justice and peace.

There are active Kaira Social Service societies in Anand, Kheda, Ahmedabad, and Panchmahal. The organization hopes that the programs will promote tolerance towards all religions. Children, women, young people, teachers, religious leaders, and dignitaries are among the participants in these activities. The organization was founded in 1967 and is registered under the Society Act as Guj/207/Kaira and the Trust Act as Kaira-F-109. The goal of the organization is to create a community that upholds ideals such as equality, social justice, peace, love, and a strong connection to the natural world.

4.1.8 Prevention and Control of HIV/AIDS and the Social System

Without a doubt, there is no permanent cure for HIV/AIDS. The prevention and management of HIV/AIDS can only be aided by a comprehensive understanding of the risks. Indians are hesitant and bashful when discussing their physical and sexual problems with other people. Such a scenario gives rise to numerous challenges and problems for society. People are afraid of stigma and discrimination, which makes them hesitant to take part in HIV/AIDS awareness campaigns. As a result, government initiatives to combat, prevent, and spread awareness of HIV/AIDS are doomed to failure. By dealing with the problem, society maintains the status quo. There have been initiatives to halt the spread of HIV/AIDS and promote an accepting environment for people living with the virus at the international, regional, and local levels. Consequently, initiatives have been taken on a number of social levels. HIV/AIDS is no longer just a medical problem; it is now a social problem that can be examined from a social science perspective. The

information and comprehension of Indian society regarding HIV/AIDS are provided below, based on a review of the literature, fieldwork, and experiences obtained during the current study.

4.1.9 Informal Norms and Values

The conventional norms and values still have a strong hold on the modern Indian social structure that controls behavior. The sexual norms here are extremely rigid when compared to other societies worldwide. Women's sexuality and the concept of the sacred are related. Consequently, it became taboo to openly discuss sexuality in social circles, and sex education was not taught in the majority of Indian states' educational systems. As a result, India could not now develop the scientific way of thinking or ideas. Perceptions of sexual norms are unchanged in India. India's women are more likely to get HIV/AIDS and other STDs than men because they enjoy less freedom than men. Individuals living with HIV/AIDS, both men and women, face social rejection and scrutiny of their actions in relation to established sexual norms. The prevalent belief in Indian society is that an individual must have committed a wrongdoing for HIV/AIDS to strike. The sacredness of women is linked to the sexual values of Indian society. She has experienced discrimination and cruel treatment ever since receiving an HIV/AIDS diagnosis. The community is compassionate and supportive toward someone with diabetes or high blood pressure, but not toward someone living with HIV/AIDS.

HIV/AIDS is a social problem because of perceptions of Indian society's sexual norms.

4.1.10 Family and HIV/AIDS

The family is the primary institution in Indian society that facilitates a child's socialization. A joint family member who gets HIV/AIDS has to live in a different house, which is found out while conducting fieldwork. HIV-positive people are excluded from the group when they genuinely need their family members' love, support, and cooperation. As a result, their social ties suffered. Among the many problems faced by the HIV-positive individuals living in separate households were not giving up their portion of the property and having to pay rent in order to reside there. India places a

higher value on family than other countries do, and both nuclear and mixed families are examples of this. The highest degree of cooperation has been noted in both kinds of families. They collaborate to find solutions in trying circumstances, but an HIV-positive person cannot expect his family to act in the same manner. He or she felt isolated as a result. There is therefore a link between the HIV/AIDS problem and the family structure. It also didn't go unnoticed during the socialization process because of a lack of sex education. Consequently, family members end up contracting HIV/AIDS and hiding their actual knowledge of it. The individual also feels embarrassed and reluctant to talk to family members about their sexual illness. This kind of social environment has been seen in Indian society, especially in the family system. As such, Indian society can approach the HIV/AIDS crisis from a variety of perspectives.

4.1.11 Marriage and HIV/AIDS

The institution of marriage holds great significance in Indian society as it is closely linked to sexual norms. Marriage legitimizes sexual behavior in Indian culture. Premarital sex has been generally prohibited, and it is taboo to talk about sexual relations and sexual necessities in Indian society due to the belief that sexual relations are sacred because marriage rites are connected to religion. People were afraid to satisfy their sexual needs for fear of upsetting society, even in situations where they married too late or in inappropriate circumstances. Consequently, they sometimes initiate risky sexual relationships out of ignorance and fear of the society. In Indian society, true scientific knowledge can only be created if sexuality norms are divorced from marriage and religion and acknowledged as a biological necessity of human beings. It is imperative to adopt this mentality in order to stop the spread of HIV/AIDS.

4.1.12 Educational Institutions and HIV/AIDS

Both types of education in Indian society are deficient in their coverage of sexuality. There are limitations or controls on sexual education, including the teaching of scientific sexuality in schools, in the majority of Indian states, including Gujarat. Even though the curriculum needs to be based on the principles of scientific knowledge, Indian

society and traditional religious beliefs have a clear influence on the current scientific education system. The family is no longer the primary social institution in any society; instead, the educational system is more important for socialization. Though the Indian educational system still upholds traditional sexual norms, in recent times there has been an increase in the value placed on education and scientific knowledge. Women and young people could not, therefore, get sex education at the right age. Thus, there has been a rise in the disease's spread due to a lack of scientific understanding regarding HIV/AIDS, safe sexual behavior, the use of condoms, and sexually transmitted infections. As a result, the Indian educational system needs to amass impartial and scientific knowledge. Not just HIV/AIDS but a host of other social issues will benefit from this kind of reform in India's school system.

4.1.13 Economic Institutions and HIV/AIDS

HIV and AIDS negatively impact the youth population in the area and depress the Indian economy. Therefore, if we want to see growth in our economy, we must put an end to the HIV/AIDS epidemic. People are unable to fully participate in their businesses or jobs as a result of these viral diseases that are preventing economic growth, which leads to dependency and a weakening of their financial situation. Thus, developing countries like India suffer from the HIV/AIDS epidemic.

4.1.14 Indian Community and HIV/AIDS

Though HIV-positive people are isolated because of the stigma and discrimination they face in society. Anomie, according to Durkheim (1897), is a state that eventually leads to risky behavior, such as suicide. Indians have always interacted with one another with empathy and compassion, but when these traits are absent from interactions with those who are HIV/AIDS positive, these people become isolated and bravely deficient. The primary groups suffer from mental disturbance and loneliness as a result of their inability to cooperate in these social situations. In actuality, they expect more from the principal groups than just collaboration. The primary groups' stigmatization and exclusion of HIV/AIDS sufferers, however, are unhealthy for Indian society.

4.1.15 Conclusion

Gujarat is implementing a number of programs in coordination with multiple departments, such as those that oversee labor, education, health and family welfare, home, and women's and children's development. As part of the third phase of the national AIDS control program, Gujarat is putting the aforementioned programs into action. These programs all promote management, prevention, and awareness of HIV/AIDS. There are still numerous societal barriers to the government's great efforts in the fight against HIV/AIDS.

Making sure that every citizen in Gujarat is aware of HIV/AIDS is the goal of the third phase of the state's national AIDS control program. To accomplish this, GSACS implemented a number of programs, such as ICTCs, Targeted Intervention,
Blood Safety Program, Sexual Transmitted Infection Care Services, Information Education Communication, etc. Still, it is not enough to increase public awareness of HIV/AIDS. For example, the IEC program raises awareness among high school and college students. But a lot of children don't go to school or university. For this reason, the government ought to act swiftly to increase HIV/AIDS awareness among children who do not attend school or college.

State governments at all levels should take a leading role in the HIV/AIDS prevention and control program. Since the prevalence and consequences of HIV/AIDS differ from state to state, state governments should create their own HIV/AIDS prevention plans and initiatives. A curriculum-based approach should be used in educational institutions to teach about AIDS. A national HIV/AIDS education program in schools and universities should be implemented nationwide in order to mobilize sizable segments of the student body to educate one another and the rest of the community. It is also important to inform young people who are not students through the vast network across the country. Worker education programs and other social development initiatives ought to include education regarding AIDS prevention.

A major media campaign was initiated by the NACO in 1996, utilizing wellcrafted generic materials. Posters, pamphlets, booklets, newspaper ads, movie clippings, TV spots, radio spots, wall paintings, and movie slides were made in Hindi in addition to all the regional languages. The government of Gujarat is trying to use the media to spread awareness about HIV/AIDS, but a large number of the state's villages are disconnected from the outside world and lack access to either rural or urban areas. A large portion of the state's population does not read newspapers, periodicals, posters, pamphlets, or watch television or listen to the radio. The messages presented in government advertisements are often too complex or unappealing for those who watch television or listen to the radio to comprehend or pay attention to. These issues can range from illiteracy or language barriers to these issues. The government should arrange street plays, puppet shows, folk dances, and other events that are more in line with the local sociocultural milieu in order to increase public awareness of the risks associated with HIV/AIDS.

Furthermore, HIV-positive individuals are viewed in a highly exclusive and discriminatory manner by the general public. To put an end to prejudice and stigma towards people living with HIV/AIDS, the GSACS has taken action. If people accept them, behave impartially, and express sympathy, those who are HIV positive will be less likely to put themselves through treatment. But it's very challenging. If such a friendly and accommodating environment is established, work for HIV/AIDS prevention and control will be extremely straightforward. To do this, the government should endeavor to disseminate accurate information about HIV/AIDS throughout society. To put it another way, if people could accept those who are HIV positive, they wouldn't have to worry about their social standing declining and would always be ready for treatment. This could contribute to a decrease in the quantity of new infections within society. People who donate blood for HIV testing at PHCs, CHCs, or district hospitals near to their homes do not return for follow-up care and counseling due to their fear of social stigma. He or she goes to a different neighborhood for a follow-up HIV test. In this instance, the government database contains two registrations for the same individual. Because of this,

the government finds it challenging to plan programs and campaigns because it is unable to ascertain the actual number of HIV positive people. Discrimination and stigma should be eradicated from people's consciousness. These might be quite helpful in controlling and preventing HIV/AIDS.

As has been made very evident throughout the conversation, there is no foolproof way to manage or prevent HIV/AIDS. There are many things that work as barriers or hindrances to the goal of the government. Numerous initiatives are carried out by the government to increase awareness among all societal members. Still, a large number of people are left out of the government's campaign. As a result, the government ought to create laws that are applicable to all citizens. The government ought to accomplish this by educating individuals about HIV/AIDS in the community and at work. It is imperative to provide HIV/AIDS education to individuals engaged in farming, agricultural work, industrial work, and other related occupations. The government needs to do a better job of taking the involvement of capable leaders from all spheres of society very seriously.

Without a doubt, the HIV/AIDS awareness campaign is a social liability. The prevention and control of HIV/AIDS is not solely the job of medical professionals; it is the responsibility of every member of society. The campaign needs to involve as many people as possible in order to protect society from HIV/AIDS. To boost public involvement in awareness campaigns and citizen participation in them, the government should act more decisively. Developing sensitive awareness campaigns and programs that are considerate of micro-sociological contexts and sites requires a strong understanding of context.

4.2 Role and Functions of NGOs

4.2.1 Introduction

Voluntary organizations, or non-governmental organizations, are another name for non-governmental organizations (NGOs). Due to the fact that a voluntary organization is made up of either paid or unpaid social workers. Its participants are the ones who start it and set its rules. Its members participate voluntarily. No matter how many people shape

it or if it comes from a single person, its activities always remain shared and form a structure of roles, status, norms, and values. Therefore, a nongovernmental organization is a voluntary organization of this kind. The present chapter attempts to elaborate the role and functions of NGOs working in the field of HIV/AIDS in [A] Arvalli [B] Sabarkantha [C] Mehsana and [D] Banaskantha districts.

4.2.2 Non-Governmental Organizations (NGOs)[1] : Meaning, Nature and type 4.2.2.1 Meaning of Non-Governmental Organization (NGO)

A non-governmental organization is a voluntary social organization driven by humanitarian values such as love, kindness, compassion, philanthropy, and service, as opposed to a bureaucratic organization. Its creators are extremely sensitive people. NGO workers and founders must exercise extra caution when diseases such as HIV/AIDS are stigmatized by society and patients are treated unfairly.

A social worker, also known as a Karmasheel, is an individual who engages in social work activities. Social workers are people who use their knowledge and expertise in social work to help and support individuals, families, groups, communities, or society as a whole. Here in [A] Arvalli [B] Sabarkantha [C] Mehsana and [D] Banaskantha in four districts of North Gujarat, NGO workers work on prevention and control of HIV/AIDS, public awareness and discriminatory treatment of patients. The focus is on protection against.

According to H. S. Gore, the main focus of social work is on welfare initiatives that fall within preexisting moral frameworks. It aims to help underprivileged people and organizations in order to rescue them from disaster and establish circumstances that will enable them to carry out their tasks effectively. It aims to achieve social upliftment by assisting the community and needy groups in reaching the highest level of their physical, mental, and social welfare. By performing relief and service operations, it offers social insurance services to the less fortunate and weaker segments of society as well as to those

[1] J. K. Dave (2014-15). Samajik Kannunikaran ane Samaj Kalyan (Gujarati). Anada Book Depo, Ahmedabad. Pp. 224-239.

impacted by disasters. People living with HIV/AIDS can receive direct psychological, social, economic, and legal assistance and services from NGO workers.

4.2.2.2 Nature of Non-Governmental Organization

An organization that is voluntary and dedicated to providing social services or welfare is known as a non-governmental organization. voluntary activities that are organized. Social workers make up this organization. A number of humanistic values, including kindness, compassion, generosity, goodwill, service, and assistance, have contributed to the formation of non-governmental organizations. HIV/AIDS initiatives are aimed at preventing discriminatory treatment of positive patients by the general public and enabling them to lead respectable, dignified lives similar to those of any other citizen.

- An NGO's welfare operations are run by employees who are either paid or unpaid. In accordance with current legislation, non-governmental organizations are required to register in order to conduct welfare operations. Its scope and structure are unique.
- An NGO's norms, values, beliefs, and code of conduct comprise its ideology, which serves as the foundation for determining the structure, methodology, and strategy of its service delivery.
- An NGO makes decisions in a straightforward, expeditious, and informal manner. Grants and donations account for the majority of an NGO's revenue. Government grants and financial assistance are given to certain organizations.
- Non-Governmental Organizations work to enable those in need to develop to the fullest extent possible. It assists the community, needy individuals, and groups in understanding their issues, coming up with solutions, getting past them, and growing into their potential. Because of this, the social worker's job is to enable the underprivileged to develop their potential.

The goal of NGOs is to make the system of supplying people with resources and services more humane and sensitive. When it comes to telling people where services and support are located, NGOs serve as both informants and guides.

NGOs' objectives are to meet the needs of the underprivileged, improve the wellbeing of those living in challenging situations, and give them a sense of empowerment. Their core values are service, social justice, human dignity, the value of human relationships, honesty, and knowledge.

4.2.2.3 Types of Non-Governmental Organizations

Types of Non-Governmental Voluntary Organizations can be listed as follows:

1) National, international, regional, and local organizations.
2) Businesses operating in both urban and rural regions.
3) Groups that assist minorities, scheduled castes, tribal people, and other underprivileged groups.
4) Businesses engaged in environmental work.
5) Groups that assist women, kids, teenagers, the elderly, people with disabilities, drug addicts, and HIV/AIDS patients.
6) Secular and communal institutions.
7) Organizations receiving Government grants and self-supporting organizations not receiving Government grants.
8) Organizations offering one or more forms of targeted services, such as aid, education, or healthcare; additionally, these organizations may offer jobs, housing, family support, or legal assistance to marginalized and underprivileged populations. As a result, there are various reasons why non-governmental voluntary organizations might be founded.

The term "social welfare" refers to programs that provide security, safety, and empowerment to all citizens of the state, but particularly to the most marginalized and vulnerable groups within society. Governmental and semi-governmental organizations use their bureaucratic structures to carry out these kinds of operations. The bureaucratic structure functions as a rational tool for social welfare, carrying out regular welfare tasks under the direction and control of authority. Humanistic virtues like empathy, service, composure, kindness, compassion, and generosity are absent from it. He is organized and

has finances. However, there is still a lack of values that are necessary for social welfare, such as sensitivity, equality, service, and the value of human relations. As a result, the successes of social welfare initiatives might be restricted.

Because of this, it is now accepted for non-governmental organizations or voluntary organizations to take part in a variety of government-sponsored social welfare initiatives. Through their inclusion in the vulnerable category list, patients with serious infectious diseases, such as HIV/AIDS, now have legal protections for their rights and a dignified life.

4.2.3 Acceptance of NGOs as public participation in social welfare

India is a democratic nation; thus social welfare participation is valued highly. In other words, voluntary or non-governmental organizations are what people's organizations and community-based organizations are known as. Social development will be equitable, as sustainable, useful, participatory, and movement-based as possible if such organizations start social welfare and development programs and use the welfare-development activities of the people, by the people, and for the people method. These programs will also assist the people in their welfare and development and create an environment where the people can achieve their development through cooperation. People's basic needs are satisfied, productivity rises, time and energy are saved, people have more choice, and welfare rises in this kind of development. Non-governmental organizations and volunteer groups have been approved for this reason in order to boost public involvement in social welfare and development initiatives.

Numerous non-governmental organizations engaged in socio-religious reform, including the Brahmo Samaj, Prathanna Samaj, Indian National Social Conference, Arya Samaj, Theosophical Society, and Ramakrishna Mission, made significant contributions to social welfare and social reform during the 19th century in India. Mahatma Gandhi founded voluntary organizations in the 20th century to carry out various social welfare initiatives, including the Swadeshi movement, village reconstruction, and the eradication of untouchability. One problem that today's society is dealing with is the HIV/AIDS

epidemic. Government and non-government organizations are trying to control and prevent it as well as raise public awareness of it.

In order to accomplish the objectives of the welfare state, non-governmental and voluntary organizations were formally recognized after India gained its independence.

The nation's Central Social Welfare Board was founded in 1953, and Social Welfare Boards were also established in the nation's Union Territories and several states in 1954. This board's mission was to advance social welfare initiatives via non-governmental organizations and voluntary organizations. It was the first board to look for volunteer organizations from the general public to help carry out welfare programs. With the creation of this board, non-governmental organizations and voluntary organizations were accepted as forms of public participation.

Welfare programs are still carried out by the Central Social Welfare Board in conjunction with the Social Welfare Boards of the States and Union Territories. At the intersection of governmental and non-governmental organizations, these Boards carry out a range of welfare initiatives.

Since 1991, the liberalization, privatization, and globalization of the Indian economy have occurred, along with a shift in people's expectations for development, making non-governmental organizations' role in social welfare increasingly significant. These developments have also highlighted the limitations of governmental and semigovernmental organizations' bureaucratic structures in implementing social welfare schemes and programs.

Humanistic ideals like kindness, compassion, and sensitivity are crucial for the well-being of society's marginalized and weaker groups. In general, the bureaucratic structures of governments and semi-government organizations lack these values. Therefore, non-governmental organizations are better suited to carry out these groups' social welfare tasks than the government. Considering that non-governmental organizations driven by humanitarian principles are voluntary organizations. NGOs/Voluntary Organizations have a sufficient role to make participatory democracy

meaningful and effective because they also have less responsibility and workload, which allows them to experiment, change the approach, and obtain the necessary information based on their fieldwork related to their field of work. are provided. This is made possible by the size and effectiveness of NGOs as well as the welfare initiatives and programs offered by the government, World Bank, and Central Bank.

4.2.4 Arrangements for participation of non-governmental organizations in social welfare

The Central Social Welfare Board, one Association, one Council, and five separate Ministries and departments have adopted the role of Non-Governmental Organizations/Voluntary Organizations in their various welfare schemes and programs. The Indian government has welcomed this development. With this arrangement, support from voluntary organizations and NGOs with a social work focus is sought for a variety of government-sponsored social welfare schemes and programs. Specialists in that field play a significant role in social welfare programs and schemes. Under various schemes, partnership arrangements with NGOs/Voluntary Organizations have been shaped in response to their demands. Under this arrangement, these organizations receive grants, or financial assistance for their programs, in accordance with government regulations. They are also assisted in various social welfare schemes and programs. These scheme programs include the following, to name a few.

(1) Welfare programs for tribes, other disadvantaged classes, and scheduled castes.

(2) Programs for the welfare and rehabilitation of the elderly, drug addicts, disabled people, and HIV/AIDS patients;

(3) Programs for the empowerment of women

(4) Employment-related programs

(5) Literacy, midday meal, and adult education programs

(6) Programs pertaining to youth and adolescent development;

(7) Programs pertaining to the establishment, instruction, and skill-building of selfhelp groups

(8) Initiatives aimed at providing the urban poor with basic services through the development of integrated housing and slums in housing schemes.

(9) Consumer education and environmental protection programs;

(10) Entrepreneurship programs;

(11) Rehab programsfor bonded laborers and child laborers;

(12) Rural development programs;

(13) Integrated watershed programs

(14) The Total Sanitation Campaign's related programs

(15) Town planning

(16) Legal aid

(17) Programs for family welfare and health

(18) Social Security programs

(19) Additional social welfare programs.

Thus, the participation of Voluntary Organizations (VOs) in various programs and schemes pertaining to social welfare and development is accepted. By doing this, efforts are made to increase the effectiveness and efficiency of social welfare programs and to strengthen public participation in the field.

4.2.5 Functioning and Role of Non-Governmental Organizations in Social Welfare

Social workers comprise non-governmental organizations (NGOs). A social worker, also known as a Karmasheel, is someone who engages in social work activities. Social workers are qualified, skilled, and knowledgeable in social work. Social work's main focus is on welfare initiatives. Professional social work is an all-encompassing endeavor. It is dedicated to helping the underprivileged, distressed, or suffering in all walks of life. Social workers are required to adhere to the Code of Conduct on Social

Work when performing social welfare tasks. In addition to improving their circumstances and their upliftment in social welfare policy and legislation, they must also promote social welfare, aid in facilitating public participation in social welfare, and carry out activities to improve the social condition of the weak, deprived, marginalized, disaster-prone, and problem-prone in society. One of their responsibilities to society at large is to advocate for reforms that are necessary. In India, numerous nongovernmental organizations and voluntary groups have grown to be active in a variety of spheres of society, providing social welfare services in accordance with their abilities and areas of interest.

From a historical standpoint, the belief that the state should prioritize the welfare of the people was prevalent in ancient India. Mahajan carries out a number of welfare tasks. It was believed that the king had a duty to provide for the needs of the elderly, the poor, victims of natural disasters, and destitute women. King Ashoka's reign saw a number of social welfare initiatives. Ashoka Raja created a complex social welfare system, and officials were chosen to carry out the welfare projects. During the Gupta administration, the welfare of the populace was regarded as a crucial state function. Some emperors, like Akbar, carried out charitable endeavors for the whole community. According to Akbar, a king ought to act in the interests of the populace.

Social welfare organizations in India started to emerge during the British colonial era, following the British model. Mumbai saw the founding of the Tata Graduate School of Social Work in 1936. This organization was the first to offer professional social work education and training. Other than this, other cities established institutions of a similar nature. Numerous socioreligious groups created initiatives for social welfare. To put an end to untouchability, Gandhiji provided innovative programs. As a result, before independence, social work and social welfare organizations in India were thriving. Various non-governmental and voluntary organizations proliferated in post-independence India and participated in state-run development and welfare initiatives.

4.2.6 Functioning of Non-Governmental Organizations in Social Welfare

As Kamal Taori points out, the charitable sector has historically been the exclusive focus of voluntary organizations' missions. However, it's getting more and more progressive these days. It is now imperative that nonprofit organizations run commercial, educational, and developmental initiatives. For voluntary organizations to fulfill the public's rising expectations, they must grow in strength. Various kinds of nongovernmental organizations and voluntary organizations carry out social welfare programs based on their personnel, interests, and mentalities. They have also registered their participation in government-sponsored welfare programs that are presented. This was said earlier. However, he repeats the operational areas here, which is repetitive. The various areas that NGOs operate in are listed below.

Programs:

- Poverty alleviation and employment-self-employment programmes
- Welfare of Scheduled Castes, Tribes, Other Backward Classes, Minorities
- Literacy, Vocational Education
- Health care and the environment
- Rural development
- Town development
- Remediation of contaminated habitats
- Women and Child Development
- Child welfare and mother welfare
- Family welfare services
- Legal aid
- Rehabilitation of disabled, child labour, bonded labour
- Development of women working in the unorganized sector
- Homemaking
- Rescue, relief, rehabilitation disabled, destitute related welfare programs in the event of natural calamities.

In summary, non-governmental organizations (NGOs) that work in a variety of areas, such as child development, labor welfare, rural development, health, education, social security, family planning, environment, housing, and employment, support the needs of social welfare by means of social welfare-related initiatives. The government offers grants-in-aid to voluntary organizations (NGOs) that carry out social welfare activities. For non-governmental organizations to be eligible for such financial assistance, they must abide by government regulations. They must also carry out the program's implementation, which is funded by the government. Through their social welfare initiatives, a variety of non-governmental organizations support human development in a sustainable manner.

4.2.7 Role of Non-Governmental Organizations in Social Welfare

In a number of government-sponsored social welfare initiatives, nongovernmental organizations and voluntary groups have been given sufficient space to improve the lot of people in India and act as a catalyst for the desired social transformations toward social justice, equality, and freedom. In government-sponsored programs that provide social welfare needs like employment, education, and health care, nongovernmental organizations are crucial. Here are descriptions of several facets of this role played by NGOs.

4.2.7.1 Contribution to Social Reconstruction

Non-governmental organizations work to address a variety of social welfare issues. Professor, as Masihi points out, the majority of volunteer organizations work to bring together the underprivileged, regressive, abused, and mistreated people and communities in order to help them escape their difficult circumstances. NGOs thus aid in social reconstruction by engaging in positive and developmental endeavors.

4.2.7.2 Empowerment

Non-Governmental Organizations place a strong emphasis on meeting social welfare needs for people. Non-governmental organizations work to enable people to access social services and facilities and complete life's tasks. He assumes the part of

Shaktiman in it. In it, social workers take on the role of counselors, helping individuals change both their personal and external environments while also growing in their capacity for adaptation and intellectual orientation.

Self-help-like skills are part of empowerment. Through the development of decision-making skills related to both individual and group circumstances, social justice and welfare, the capacity to think positively in order to change one's circumstances, the capacity to blend in with society, the capacity to cultivate a positive self-image, and the capacity to discern between right and wrong with discretion, non-governmental organizations strive to empower people.

When a problem is empowered in this way, people are compelled to continue developing their basic human activities. For them, this form of development turns into sustainable development. Thus, the work that non-governmental organizations (NGOs) do to empower the affected population improves their quality of life, helps them rise up, and helps them become independent and growth-oriented individuals, all of which contribute to the prosperity and well-being of their offspring.

4.2.7.3 Eases the Government's Burden

The government has established partnerships with NGOs and accepted their role in social welfare and development across a range of fields. These partnerships include regulations governing the projects that NGOs may undertake in connection with government-sponsored welfare and socioeconomic development initiatives. Grants are given out in exchange for financial assistance, which lessens the government's administrative and financial burden. As a result, NGOs' involvement in governmentsponsored initiatives for social reconstruction and empowerment lessens the administrative and financial strain on the state.

4.2.7.4 Role as a Safety Valve

Through their participation in a range of social welfare initiatives, nongovernmental organizations function as a kind of safety valve in society. The problem and distressed people, as well as the weaker and more deprived segments of society, are

unhappy with their circumstances and experience hopelessness and depression. Therefore, it's possible that they'll choose to fight their way out of this predicament. Non-Governmental Organizations serve as a social safety valve by removing agitation and conflict and providing a constructive outlet for people's resentment and frustration through social welfare initiatives.

Donations are a source of funding for non-governmental organizations engaged in social welfare initiatives. He appeases the people's philanthropic and spiritual spirits in this way. The donor feels satisfied that he has paid his debt to society and performed a good deed. Donation money is utilized for social welfare initiatives. Redistribution of wealth occurs in society in this way. Rich people's money helps the less fortunate meet their basic needs and become self-sufficient, serving as a safety valve to keep unhappiness from showing. As a result, NGOs function in society as a sort of safety net.

4.2.7.5 Providing Social Insurance Services

Through a variety of social welfare initiatives, non-governmental organizations help the elderly, the poor, the sick, the disabled, the victims of natural disasters or accidents, the displaced, the destitute, needy women and children, etc., get back to their regular lives. establishes a supportive environment. In this sense, NGOs satisfy the need for social insurance by offering disturbed and distressed people a semblance of security cover.

4.2.7.6 Social Awareness

NGOs' social welfare initiatives raise people's awareness of their predicament, inform them of their rights, and let them know what services are available. Inspires them to move in unison and organizes them to escape the circumstance. Engaging in such activities makes society and the government more aware and compels them to take the appropriate action. This kind of social awareness cultivation facilitates social action.

4.2.7.7 Social Actions

Some NGOs also carry out the essential tasks to enhance peoples' conditions. Social workers are the ones who organize these actions. Individual or group effort can be used as a form of social action. Such action could take the form of filing a lawsuit, staging a sit-in, or holding a demonstration in support of a government or semigovernment organization. Enhancing social policy, enacting new legislation or reforming existing ones, or enhancing a range of welfare services are the objectives of such social measures. By educating the public, non-governmental organizations influence referendums through socialization. These actions are taken in opposition to the issues of child labor, child labor rehabilitation, the status of female workers, housing issues, slums, female genital mutilation, education of girl children, crimes against women, and rape. These actions are linked to improving those people's situation.

4.2.7.8 Role as Agents of Social Change

Through their various social welfare initiatives, non-governmental organizations work to change the lives of the most marginalized and vulnerable members of society in the direction that is desired. Non-Governmental Organizations try to implement new laws, develop sensitivity in the bureaucratic structure of Government and SemiGovernment organizations, and address issues pertaining to housing, employment, health care, education, and other areas that affect the weaker and deprived groups. They also attempt to make necessary legal reforms. It makes an effort to eradicate the causes of inequality and injustice. Through efforts to empower individuals, families, and communities, it works to remove barriers from the path of life for the weaker and disadvantaged groups and also acts as an agent of change in the desired direction.

4.2.7.9 Role as a Facilitator in Human Development

Through their participation in a range of social welfare initiatives, nongovernmental organizations contribute to human development. Evolution in humans is a series of transformations. Through social welfare initiatives run by NGOs, the

underdeveloped developmental potentials of the weaker and disadvantaged groups start to show signs of life.

The institutionalization of laws pertaining to social welfare and education has been given priority in the current stage of human evolution. Non-governmental organizations that engage in welfare work help weak and disadvantaged groups build their capacity for development and strengthen their ability to overcome obstacles in life and obtain services. It is possible to enact new laws, reform existing ones, and ensure their enforcement through social action. In addition to participating in public policymaking, non-governmental organizations work to empower the illiterate by educating and empowering them with vocational skills. They also support the process of universalizing education. To accelerate human evolution, it becomes necessary to include those who are excluded from various spheres of social life, such as politics, employment, education, and other areas, because of their caste, sex, age, or gender. Society's ability to function can be improved by doing this. Non-Governmental Organizations (NGOs) engage in initiatives to break down barriers and encourage social inclusion of marginalized and vulnerable groups, as well as victims of particular circumstances. The process of social inclusion is evolutionary. As a result, nongovernmental organizations' welfare initiatives that quicken social inclusion also facilitate and quicken human evolution, which is a prerequisite for sustainable development and becomes crucial to the globalization process. As a result, NGOs aid in the development of people.

4.2.7.10 Role as a Facilitator in Building a New Work Culture and Civil Society

Human rights protection is one of the missions of non-governmental organizations. Human rights advancement is greatly aided by activists. The ethical impact of non-governmental organizations operating in that domain can result in favorable attitude shifts within the bureaucracy, fostering the essential awareness within the bureaucracy for social welfare. Realizing human rights is social welfare's ultimate goal. Human rights are the foundational principles of liberal democracy.

Non-governmental organizations possess the capacity to significantly aid in the creation of a new workplace culture that is compliant with human rights. Nongovernmental organization employees can help raise public awareness of India's status as a democratic society, a legal state, and a welfare state. A new, result-oriented work culture can only be established with this kind of awareness.

The core values of the new workplace culture are honesty, integrity, compassion, and a dedication to the freedoms and dignity of all people. Eliminating procrastination, rules and fair conduct, eliminating system weaknesses, reforming bureaucratic structures in accordance with human rights, and refraining from selfish activities. NGOs have a significant role to play in making sure that appropriate oversight and control, public outreach, a positive outlook, transparency in the workplace, and other factors become ingrained in the workplace culture and core values. In a democratic society, non-governmental organizations and voluntary groups are people's power and can help develop and support civil society by fostering a new workplace culture. The welfare of HIV/AIDS patients is the focus of non-governmental organizations working in the field. In order to give them the opportunity to live a life of dignity free from discrimination, efforts are made to safeguard their rights.

4.2.7.11 Contribution to Accumulation of Socio-Applicable Knowledge

Non-governmental organizations have a significant impact on the body of knowledge that is relevant to society. Employees of NGOs perform the functions of social scientists and researchers. Prof. As Masihi points out, voluntary organizations (NGOs) compile the data required by their industry to support and maintain innovative and developmental endeavors. There are NGOs that have their own documentation department, library, and research department. They maintain contact with local organizations that carry out comparable social welfare initiatives. He compiles knowledge from his professional experience and applies it to his social welfare work to make it more goal-oriented. Such knowledge also adds to the body of information that is beneficial to society and is published bibliographically as a book. Planners of government

policy, social workers, and other social welfare organizations can all benefit from this accumulation of knowledge. Social sciences can advance via the same kind of information gathering. Social welfare organizations, social workers, the government, and policy makers can all benefit greatly from the information gathered through the efforts of various NGOs involved in the HIV/AIDS crisis.

Therefore, by collaborating on government-sponsored social welfare events and initiatives, NGOs/Voluntary Organizations can play a variety of roles in social welfare. According to Kamal Taori, in order to partner on a social welfare program, certain HIPPOO (Hidden Investable Potential Power of Organization) and KIPPOO (Known Investable Potential Power of Organization) elements must be chosen. That is, the nongovernmental organization's covertness—that is, it is important to distinguish between known and unknown latent forces and choose the right non-governmental organization from among them. If this is done, the nation's great values—humanity, reason, justice, transparency, and equality—can be the cornerstone of development. Non-governmental organizations are the people's power in a democratic society, and they can help to build and support civil society.

4.2.8 Role of UNO

The Joint United Nations Programme on HIV and AIDS, or UNAIDS, is the main advocate for prompt, comprehensive, and coordinated international action against the HIV/AIDS pandemic. UNAIDS strives to lead, strengthen, and support an expanded response to HIV and AIDS in order to prevent HIV transmission, care for those who have the virus, reduce vulnerability of individuals and communities to HIV, and lessen the effects of the epidemic. UNAIDS aims to slow the rapid spread of the HIV/AIDS pandemic.[2]

[2] http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india

4.2.9 Five Goals of UNAIDS

a. Strategic information and technical assistance to support efforts against AIDS globally;
b. Tracking, monitoring, and evaluation of the epidemic and of responses to it;
c. Engagement of civil society and the formation of strategic partnerships;
d. Mobilization of resources to support an effective response.
e. UNAIDS is headquartered in Geneva, Switzerland, and makes use of certain World Health Organization buildings there as well. It is a member of the United Nations Development Group. UNAIDS's first executive director was Peter Piot. UNAIDS's mission is to support and facilitate the development of a broader response to HIV/AIDS, involving numerous partners in both the public and private sectors.[3]

UNAIDS encourages cooperation between these many different kinds of nonstate organizations. This calls for an increase in the number of new actors as well as creative working methods to enable increased capacity of non-state entities to respond to the epidemic at all levels in an effective manner.[4]

India is home to one of the greatest concentrations of HIV-positive individuals in the world. Even though it is generally accepted that prevention and treatment are complementary tactics in the fight against HIV/AIDS, the Indian government has prioritized prevention over treatment. Additionally, HIV/AIDS patients face severe discrimination and stigmatization. To support people living with HIV against all forms of discrimination, the HIV/AIDS and the Law Initiative at HRLN upholds their fundamental human rights, including their right to life, health, privacy, education, employment, housing, and other issues.[5]

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[3] http://www.worldbank.org/projects/P078538/third-national-hivaids-control-project?lang=en)
[4] http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=38061&Cr=hiv&Cr1=#.Uqbn3NIW1_Q
[5] http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=37950&Cr=HIV&Cr1=#.Uqbn_9IW1_Q

With UNDP assistance, the Integrated Network for Sexual Minorities (INFOSEM) and 29 district-level PLHIV networks have been formed. 15.6 million people, including service providers, received information and training that improved their ability to protect themselves against HIV. UNDP India is currently focusing particularly on addressing punitive laws and environments that affect the inclusion of the criminalized and marginalized groups, in accordance with the joint UN Framework for Action. Working with networks of HIV-positive individuals and NACO, UNDP has been successful in enacting policy changes in 35 government programs that grant access to various entitlements for those affected by HIV. Free transportation, food aid, legal support, microgrants, short stays at home, livelihoods, education, and pensions are a few of these programs. As an example, Rajasthan was the first state to modify the widow pension program to cover widows with HIV who are widows regardless of age.[6]

He declared, "There is no doubt that we have made much more progress," citing, among other things, the fact that, at the time of the previous General Assembly special session on the topic in 2001, less than 200,000 people were receiving treatment for AIDS. Currently, about six million people are receiving treatment for the disease. He went on, though, pointing out issues like defending the rights of men who have intergalactic sex, drug injectors, sex workers, migrants, and other marginalized groups.[7] The report highlights how brittle the progress is. Every patient starting antiretroviral therapy results in two new HIV infections, and there are 7,000 new infections every day, 1,000 of which are in children. [8]

The Secretary-General offers five suggestions in the report for bolstering the AIDS response, two of which are to revive the push for universal access to HIV prevention, treatment, care, and support by 2015 and to harness the energy of young people for a revolution in HIV prevention.[9]

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[6] http://www.undg.org/docs/9727/A-Resource-Guide-forTheme-Groups.pdf
[7] http://www.ekh.lu.se/media/ekh/forskning/mfs/8.pdf
[8] www.globalaidspartnership.org/html/ngos.htmls#ngoii
[9] www.blogaids.gov/2012/09/nih-research-on-hiv-and-aging.html

Other suggestions he makes for cooperating with countries to enhance the affordability, effectiveness, and sustainability of HIV programs include the promotion of women's and girls' health, human rights, and dignity as well as making sure that commitments are kept in the AIDS response through mutual accountability.[10]

A global epidemic of this magnitude and complexity, which raises issues beyond health, requires action from an international organization. UNAIDS was established in 1996 as a result of the UN system taking action to address the HIV/AIDS problems. UNAIDS is a novel collaboration comprising seven co-sponsors, namely UNESCO, UNICEF, UNFPA, WHO, UNDP, UNCP, and the World Bank. The mission of UNAIDS is to advance global action against HIV/AIDS. A range of HIV/AIDS-related projects are funded by each partner organization in collaboration with governments, civil societies, and the private sector. A major turning point in the global effort to combat the AIDS crisis was the June 2001 special session of the UN General Assembly dedicated to HIV/AIDS. As stated in the United Nations, 2000 Millennium
Development Goal 6, leaders of 189 Member States pledged in the United Nations, 2001 Declaration of Commitment on HIV/AIDS to a comprehensive set of time-bound HIV targets to halt and begin reversing the global epidemic by 2015.[11]

4.2.10 Increasing Our Efforts to End HIV and AIDS

Political Declaration on HIV and AIDS

a. From June 8 to June 10, 2011, heads of state and government, along with representatives from various states and governments, convened at the UN to assess the status of the implementation of the HIV/AIDS Political Declaration of 2006 and the 2001 Declaration of Commitment on HIV/AIDS. Our objective was to support leaders' ongoing political commitment to and involvement in a comprehensive response at the local, state, and federal levels in order to guide and bolster the global response to HIV and AIDS.

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[10] www.ngopulse.org/article/guide-hiv-aids-ngos-southafrica
[11] www.ncbi.nlm.nih.gov/pubmed/12284229

b. reaffirm that the UN Charter protects Member States' sovereign rights and that all countries must carry out the promises and commitments made in the current Declaration in line with domestic development priorities, international human rights, and national law;

c. Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, highlighting the critical need to step up efforts to ensure that everyone has access to comprehensive prevention programs, care, treatment, and support;

d. Although HIV and AIDS are global diseases, each country's epidemic is distinct in terms of its causes, susceptibilities, aggravating factors, and affected populations; therefore, responses to each unique scenario must be customized by the international community and the affected countries, taking into account the epidemiological and social context of each one;

f. Recognize the significance of this high-level meeting, which marks the tenth anniversary of the adoption of the Declaration of Commitment on HIV/AIDS, the fifth anniversary of the Political Declaration on HIV/AIDS, and the first anniversary of the first report on AIDS. It also honors the commitment to rapidly scale up responses to ensure that everyone has access to comprehensive prevention programs, treatment, care, and support.[12]

4.2.11 Eliminating AIDS-Related Illness and Mortality Through Treatment, Care, and Support

a. promise to intensify efforts to raise everyone living with HIV/AIDS'squalityof life and life expectancy;

b. declares your determination to intensifying your efforts to fulfill the objective of providing everyone with access to antiretroviral treatment for those who meet the requirements in line with the WHO treatment guidelines, which demand the early

[12] www.iseac.ac.in/prc-abs17.pdf

start of high-quality care for the best results. By 2015, you want to have enrolled 15 million HIV-positive individuals in antiretroviral therapy;

c. Declare your commitment to assisting in the provision of high-quality, reasonably priced, highly effective, safer, and more straightforward treatment plans that avoid drug resistance; as well as straightforward, reasonably priced point-of-care diagnostics; cost savings for all essential components of treatment delivery; community mobilization and capacity building to assist treatment scaling up and patient retention; and initiatives that promote enhanced;
d. Assume responsibility for developing and putting into action plans to improve infant HTV diagnosis, including point-of-care diagnostic access; greatly expand and improve treatment options for children and adolescents living with HIV, including prophylaxis and treatments for opportunistic infections; raise the financial, social, and moral support systems for parents, guardians, and other caregivers; and enhance access to diagnostics at the point of care.
e. Become dedicated to promoting comprehensive, high-quality, reasonably priced primary health care and support services, including those that deal with the mental, emotional, physical, and social aspects of living with HIV; additionally, provide services that integrate the prevention, treatment, and management of co-occurring conditions, such as hepatitis and tuberculosis;[13]

4.2.12 Resources for the AIDS response AIDS

a. Make sure that funds go through national finance systems when necessary, and make a commitment to working toward 2015 to close the $6 billion annual global HIV and AIDS resource gap, as estimated by the Joint United Nations Programme on HIV/AIDS. This will be accomplished by increasing strategic investment, continuing national and international funding to help nations access stable and sustainable financial resources, and finding creative sources of funding.

[13] http://ekg.lu.se/media/ekh/forskning/mfs/8.pdf

b. Ensure that synergies are tapped into between the HIV and AIDS response and the legal trade in generics and other inexpensive medications. Commit to enhancing the efficacy of prevention by concentrating interventions to deliver more creative, inventive, and long-lasting programs for the HIV and AIDS response, in line with national development plans and priorities.
c. To reach a significant level of annual global expenditure on HIV and AIDS, commit by 2015 to increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources. Recognize that the Joint United Nations Programme on HIV/AIDS has set an overall target in low- and middle-income countries that is estimated to be between 22 and 24 billion dollars.[14]

4.2.13 Integrating HIV and AIDS with broader issues of health and development while bolstering health systems

a. With a focus on the nations most impacted by HIV and/or emigration, support and promote the significant development of human capital, the growth of national and international research infrastructures, laboratory capacity, enhanced surveillance systems, and the training of basic and clinical researchers, social scientists, and technicians through domestic and foreign funding and technical assistance.
b. By 2015, make sure that funding is allocated to and the connections between HIV and tuberculosis responses, primary healthcare services, sexual and reproductive health, hepatitis B and C, drug dependence, non-communicable diseases, and maternal and child health are strengthened through collaboration with partners. HIV/AIDS prevention through the use of health care; enhancement of the interface between HIV services, related sexual and reproductive health care and services, and other health services, such as maternal and child health; elimination of parallel systems for HIV-related information and services where practicable;

[14] www.tnhealth.org/tsngo.htm

and fortifying ties between national and international initiatives pertaining to human and national development, including the eradication of poverty.[15]

4.2.14 Role of NGOs

NGOs play a critical role in HIV/AIDS prevention because of their close collaboration with individuals who participate in high-risk behavior. In addition to providing funding to numerous NGOs, the government is trying to create an effective network in order to alter behavior and increase public awareness. Promoting safe sexual behavior and educating marginalized populations about high-risk behavior are the objectives of NGO collaboration. Additionally, it helps grassroots NGOs that run population- and neighborhood-specific intervention programs. CBOs and NGOs that work on intervention projects make up the first group. The second category comprises organizations that support individuals living with HIV/AIDS, with a focus on initiatives for care and support aimed at mitigating its effects. It runs newspaper ads soliciting NGO proposals as part of its transparency policy. The selection of NGOs is done in three steps: 1) The proposal was given careful consideration by the Technical Advisory Committee and the NGO Advisor. 2) A zonal officer's pre-approval inspection conducted in the field. 3) The approval of the Executive Committee. The NGO Advisor assesses all proposals from NGOs, and Zonal Officers visit the sites of recommended proposals to verify the organization's capabilities, operational status, and community perception. After the field inspection, the proposals and reports are brought before the Executive Committee. Subject to Committee approval and following the signing of the required contract, funds are disbursed to the NGOs in installments. Intervention programs try to encourage safe behavior by providing condoms, counseling, and STD treatment services to marginalized and vulnerable groups. NGOs have located and contacted 17 of these groups thus far. The groups identified for intervention programs include truck drivers, commercial sex workers, migrant labor, industrial workers, refugees, fishermen, slum dwellers, hotel and lodge employees, domestic help, students, street children, and MSMs. It also builds

[15] www.socialcapital.weebly.com/uploads/1/0/5/9/1059736/kabeba-social-capital-building-in-uganda.pdf

relationships with NGOs to guarantee that the HIV/AIDS situation is suitably and sufficiently addressed.

NGOs are asked to open house meetings each year so that the Hon. Health Minister can interact with them. It also hosts conferences where non-governmental organizations (NGOs) can share experiences and benefit from each other's domain knowledge and experience. NGOs can attend training sessions on project preparation and management in addition to workshops and seminars. Through NGOs, they back the following initiatives:

a. Counselling
b. STD treatment
c. Condom promotion
d. Treatment for opportunistic infections
e. Home care for people living with AIDS
f. Networking PLWH/A

Interventions with a priority focus for high-risk populations. The targeted intervention program aims to lower the rate of transmission among the most marginalized and vulnerable populations. One way to stop the disease from spreading further is to implement multi-pronged direct intervention programs among these groups. These programs should start with behavior change communication, counseling, health care support, treatment of STDs, and creating an environment that will facilitate behavior change. Targeted intervention is one of the most important components of the National AIDS Control Programme's Phase II. The National AIDS Control Program's Phase I, which ran from 1992 to 1999, gave environmental improvement projects and awareness-raising campaigns a lot of attention. Nonetheless, the focus of the National AIDS Control Programme, Phase II 1999–2004, has shifted from raising awareness to changing behavior through intervention, particularly for populations who are at a higher risk of HIV/AIDS. Plans from NACO state that NGOs are critical to stopping the HIV/AIDS epidemic. They are vital in the struggle against discrimination and stigma towards HIV/AIDS sufferers. The conventional method of persuading nongovernmental

organizations to endorse government programs has only been applied to non-health related fields. Consequently, well-established NGOs have stayed away from HIV/AIDS-related work.[16]

First, the condom promotion program was part of the state's Family Welfare Program. Furthermore, the condom promotion program is now overseen by the State AIDS Control Society via the District Health Offices, Municipal Corporations, and Civil Hospitals. This importance has been considered in the preparation of the condom distribution plan. The Family Welfare Program has made condom distribution free of charge in accordance with this plan. By the end of March 2004, 2,71,32,968 condoms had been distributed by the Family Planning, AIDS, and STD Control Program; during 2003–2004, a social marketing campaign distributed 36,000 condoms.[17]

The continuous and significant transition from a traditional, rural, and relatively stable social structure to a contemporary, competitive, and unstable urban environment must be considered in any HIV/AIDS prevention and control strategy. Globalization's effects on customary cultural practices and value systems have brought about advantages as well as annoyances.[18]

Cultures aren't always the same. One constant feature is diversity. Culture is also never a frozen, fossilized, or monolithic system. On the other hand, culture is a dynamic product of evolution. It has internal dynamics that are part of its nature. At the same time, each culture appropriates aspects of the other. They appropriate ideas, viewpoints, and actions, whether they are traditional, contemporary, or concrete. A society or a specific population is constantly undergoing a wide range of external socio-economic transformation processes, which they participate in and are impacted by. Therefore, culture helps to revive, preserve, reinterpret, modify, and recreate traditions and ethos. These evolutionary variations, multiple dimensions, and modern cultural adaptations

[16] www.macrothink.org/journal/index.php/jpag/article/view/2732
[17] www.catholicrelief.org/hiv-aids/partners.cfm
[18] www.hivcode.org

must be considered in the design, implementation, and evaluation of HIV/AIDS prevention and care strategies.[19]

For this reason, comprehensive, varied, cross-disciplinary, trans-institutional, and inter-sectoral strategies and policies for HIV/AIDS prevention and care are required. In conclusion, the following factors need to be considered in cultural approaches:

It is vital to respond to the epidemic with efficacious measures. The overarching goals of SANKALP's action plans are as follows: a. identify the relationships between the epidemic and its social surroundings; b. view social and cultural elements as both assets and obstacles in the process of development; and c. acknowledge the significance of considering a society's overall structure in addition to its cultural characteristics in general. d. guaranteeing the widespread mobilization of families, individuals, communities, and governmental and non-governmental organizations; e. increasing public awareness of the need for behavior modification; The main target groups for the organization's HIV/AIDS control and prevention programs are risk groups such as displaced individuals, commercial sex workers, people in mobile professions, segregated groups, homosexuals, and dysfunctional families.[20]

While some NGOs have concentrated on empowering individuals, especially through counseling, it's possible that they are unable to lessen the psychosocial problems and social stigma associated with HIV/AIDS. For example, the AIDS Information Centre (AIC) does not increase people's power through social capital initiatives, despite being the best organization for offering voluntary, high-quality HIV/AIDS counseling and testing. Thus, while AIC prioritizes disseminating broad information regarding HIV/AIDS, JSS prioritizes disseminating detailed information about the illness.[21]

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[19] www.chinaperspectives.revues.org/498

[20] http://aids.gov/federal-resources/around-the-world/global-hiv-aids-organization

[21] http://www.humanrights.is/the-human-rights-project/humanrightscasesandmaterials/humanrightsconceptsideasandfora/theconceptsofhumanrightsanintroduction/definitionsandclassifications/(concept)

However, it shouldn't be seen as an indication of AIC's shortcomings. Rather, it ought to be regarded in the context of the reality that each organization has a goal that it works toward. At AIC, we provide excellent voluntary HIV counseling and testing with the guiding principle of protecting clients' HIV/AIDS status. Therefore, we are speculating that these organizations might not be able to successfully mobilize the social capital needed to lessen the effects of HIV/AIDS.[22]

It will take more effort to effectively fight HIV/AIDS. Government grassroots programs, for example, are supposed to exist, but they have only existed on paper. Officials from the district directorate of health services claim that there isn't a response from the local level of government. These officials made the point that a significant percentage of local responses are handled by NGOs. NGOs are more effective than the government, despite their smaller size, according to a government official.[23]

4.2.15 NGOs, Solidarity and HIV/AIDS challenges

Social exclusion, stigmatization, self-denial, and self-exclusion brought on by HIV/AIDS had a divisive impact right away. These were the first difficulties that HIV/AIDS patients had to deal with. Paradoxically, these difficulties have come to define the PLWHA identity. The way society saw them—including discrimination and stigma—inspired these people to form solidarity groups and band together. Some of these organizations—some of which have grown to be fairly large—address a variety of HIV/AIDS-related issues, including care, support, counseling, sensitization, advocacy, and resource mobilization. These have continued to be the main pillars of the antiHIV/AIDS movement since the late 1980s. People living with HIV/AIDS can now exchange experiences, contribute to development, and obtain information and resources (material and financial) through these vital channels.[24]

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[22] http://www.humanrights.com/what-are-human-rights/brief-history/cyrus-cylinder.html
[23] http://www2.ohchr.org/english/issues/hiv/introhiv.htm
[24] http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07

4.2.16 Institutional Competences of NGOs

NGOs possess the institutional expertise necessary to mitigate the effects of HIV/AIDS. We enumerate the competencies that NGOs possess in this section. One of the following skills is the capacity to create an identity in order to fight for a common cause: a. creating capacity; b. managing participatorily; c. creating policies; d. mobilizing resources;[25] The NGOs have partnered with one another and established mutually beneficial relationships with the government as a result of their connections. Consequently, there has been an improvement in the coordination of activities and programs, as well as between AIDS-affected individuals and NGO personnel. Two instances of organizational collaboration are the introduction of collaborative HIV/AIDS programs and the previously mentioned referral system. To assist in the execution of its programs, one organization may hire another in this regard. For example, Population Service International (PSI), a commercial services company, hired the TASO drama group in 2003 to notify the public on its behalf. There is no such group at PSI.[26]

4.2.17 Role of Government in Protection of HIV/AIDS

The Government of India (2009) estimates that 2.40 million Indians (1.93-3.04 million) are HIV positive, with an adult prevalence of 0.31%. 3.5% of individuals under the age of 15 and 83% of those between the ages of 15 and 49 are afflicted by infections. 39% (930,000) of HIV infections are in women. Mostly in the industrialized south and west as well as the northeast, a small number of states contain the majority of India's incredibly diverse epidemic. The country's HIV infections are concentrated in the 55%. 55% of all HIV infections in India are found in the four high prevalence states of South India: Andhra Pradesh (500,000 cases), Maharashtra (420,000 cases), Karnataka (250 000 cases), and Tamil Nadu (150 000 cases). With an estimated 100,000 or more PLHA each, West Bengal, Gujarat, Bihar, and Uttar Pradesh collectively account for 22% of HIV infections in India.

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[25] http://www.equalpartners.info/Chapter2/ch2_1How.html

[26] http://csis.org/files/media/csis/pubs/071120-india-hivaids-public-health-strategy.pdf

The HIV epidemic primarily affects populations at risk for the virus in India. The use of tainted injecting equipment for drug injection and unprotected sex between prostitutes and their clients are the primary causes of the concentrated epidemics. HIV prevalence rates are high and continue to be high in many of the most vulnerable populations. The main way that HIV is spread in India, according to the National AIDS Control Organization (NACO), is through unprotected heterosexual sex. The maturing of the epidemic has resulted in a greater proportion of HIV-positive individuals being women, particularly in rural areas. The population appears to have been protected thus far by the low prevalence of concurrent sexual relationships with multiple partners in the larger community. Even with relatively small increases in the rate of HIV infection, there are still a lot of new infections in a country with a population of over a billion people, even though overall prevalence is still low.[27]

4.2.18 Risk Factors

Many factors put India at risk of rapid HIV spread if effective prevention and control measures are not expanded nationwide. These danger factors include the following: The main causes of reported HIV cases in India are unsafe sex and low condom use. HIV prevalence is high among sex workers (male and female) and their clients. In 87.4% of cases, sexual transmission is the cause as well. The majority of HIV-positive women seem to have gotten the virus from a regular partner who had paid sex and was exposed to it. Overall, there is a growing push in India to prevent HIV among sex workers. But the nature of sex work is complex, and the application of outdated laws frequently makes it more difficult to prevent and treat HIV. Despite recent data suggesting an increase, condom use is still limited in many places, particularly where business encounters take place in 'risky' areas where police tolerance for this activity is low. Furthermore, the minority of sex workers who work in brothels is often the focus of

[27] B. Ramesh, "Sex Work Typology and Risk for HIV in FSWs in Karnataka", paper presented at the XXI International AIDS Conference, Toronto, August 13- 18, 2006, http://www/aids2006.org/PAG/Abstracts.aspx?AID=9062

interventions. Particularly among those who work in the streets, sex workers are not well-informed about HIV. Certain preventive initiatives, for example, sponsored by sex workers' cooperatives in Sonagachi, Kolkata, have been associated with a decreased HIV prevalence by encouraging safe, paid sex practices (Kumar, 1998; Jana et al., 1998). According to recent HSS 2010–11 data, the three states with the highest HIV prevalence among FSWs are Karnataka (5.35%), Maharashtra (7%) and Mizoram (27%).[28]

Infection rates among expectant mothers and their babies have been rising in some states as the epidemic spreads through demographic groups that are bridging one another. Like in many other countries, women's low status and unequal power relations—which show up as limited access to human, financial, and economic resources—weaken women's ability to defend themselves and negotiate safer sex both inside and outside of marriage. Their susceptibility is heightened by this. Considerable Stigma: The stigma associated with being HIV positive is very strong. Preexisting discrimination is strengthened and supported by the myth that AIDS exclusively affects women who have sex with men, sex workers, and drug injectors.[29]

The second phase of the NACP concluded in March 2006, having started in 1999. During this phase, India continued to expand the program at the state level. Preventive interventions for the general public, targeted interventions for the populations most at risk, and the involvement of non-governmental organizations and other sectors and line departments, such as education, transportation, and law enforcement, were given more weight. Capacity and accountability at the state level continue to be major issues that require constant assistance. In order to reach a greater proportion of the population, interventions must be expanded and monitoring and evaluation must be improved.[30]

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[28] Rajesh Kumar, "Trends in HIV-1 Young Adults in South India from 2000 to 2004: A Prevalence Study, "The Lancet 367 (2006), pp. 1164-72, http://www.thelancet.com/journals/lancet/article/PIIS0140673606684353/fulltext

[29] Pramit Mitra, "AIDS Threatens India's Prosperity," http://yaleglobal.yale.edu/display.article?Id=8486

[30] http://Tnhealth.org.tsngo.html

4.2.19 Numerous NGOs and CBOs

India is home to a considerable number of NGOs and CBOs that are involved in HIV/AIDS issues at the local, state, and federal levels. Projects include direct care for HIV-positive people, general awareness campaigns, targeted interventions with key populations, and care for children left orphaned by AIDS. Non-governmental and community-based organizations receive funding from a variety of sources, including the Indian federal and state governments, international donors, and local contributions. Furthermore, several Community-Based Organizations (CBOs) have experimented with innovative approaches to address the stigma and discrimination that hinder the most vulnerable populations from receiving efficient HIV prevention, treatment, and care services. Many sources provide India with funding and technical support. India receives financial and technical support from several bilateral donors and UN partners. NACO has partnered with DFID and the World Bank to finance NACP3. A few examples include the Clinton Health Access Initiative, UNAIDS, UNFPA, UNICEF, UNDP, and WHO; other organizations include the USG (USAID, CDC, and PEPFAR); the Bill and Melinda Gates Foundation's Avahan program; and DFID.[31]

In 1992, the World Bank provided a credit of 84 million dollars to establish the first National AIDS Control Project, marking an increase in collaboration between the World Bank and the Indian government on programs aimed at combating infectious diseases since 1991. The project helped the government establish the institutions and procedures needed to halt the spread of HIV, as well as to expand prevention initiatives. In order to expand on the knowledge acquired from the first project, India approached the World Bank for funding for a follow-up project. The World Bank provided US$191 million to launch the Second National HIV/AIDS Control Project.[32]

Nonetheless, the state needs to realize that by carrying out its regular operations, it frequently directly influences the level of susceptibility to H1V infection, either rising

[31] http://Maha-arogya.gov.in/programs/nhp/aids/ngo.html
[32] http://sankalp.org/hivaids

or falling. For example, if the state is unable to sufficiently provide services like housing, electricity, water, and sanitation, it is not meeting its responsibility to provide the resources required to enable people to make "safe sexual choices."

The primary goal of the first National AIDS Control Programme (NACP), which ran from 1992 to 1999, was to monitor HIV infection rates among populations in certain urban areas that were considered at risk. During the second phase, which ran from 1999 to 2006, the original program was expanded at the state level with an emphasis on targeted interventions for high-risk groups and preventive interventions for the general public. The Prime Minister oversaw the National Council on AIDS, which was comprised of 31 ministries at this time. HIV/AIDS was acknowledged as a health concern as well as a development issue, leading to its mainstreaming into all ministries and departments. In order to reverse the epidemic, the third stage greatly expanded targeted interventions and included programs for care, treatment, and support. By the end of 2008, approximately 932,000 of the most vulnerable individuals—that is, 52% of the target groups—had gotten targeted interventions (49% of FSWs, 65% of IDUs, and 66% of MSM). India created a "National HIV and AIDS Policy and the World of Work" in 2009 to stop discrimination against employees based on their real or perceived HIV status. This policy encourages all public, private, formal, and informal businesses to create workplace policies and programs that are grounded in the values of nondiscrimination, gender equity, a healthy work environment, abstaining from screening applicants for jobs, confidentiality, prevention, care, and support.[33]

States in India also differ in their capacities to contain the pandemic. The southern states have the best health infrastructure, the highest levels of political awareness, and a seemingly greater willingness to fight the AIDS pandemic. The greatest level of HIV prevention efforts has been in southern India. However, certain northern states have

[33] Vrajlal K., Sapovadia, “Controlling HIV/AIDS - A Judicial Measure, Recommen- dations by Supreme Court of India.”

notoriously subpar healthcare and governance systems. The most recent survey estimates that the prevalence is high in these 29 districts, some of which are in the states of West Bengal, Orissa, Rajasthan, and Bihar. They haven't gotten as much attention as those who do since they don't live in "high-prevalence states." Given that Bihar's high-prevalence districts are close to Nepal's infamously porous border, there's a chance the epidemic there will spread more quickly.[34]

The National Policy on HIV/AIDS and the World of Work was created by the Ministry of Labor & Employment and presented to the Standing Labor Committee during its 43rd session. The policy was developed by the Ministry of Labor and Employment following consultations with social partners, the National Aids Control Organization, and the International Labor Organization. Additional policies, guidelines, and groups providing protection to HIV/AIDS patients include:

- Daman, Diu Public Health Act, 1985 Goa, Amended in 1986
- Indian Penal Code, 1860
- Drugs and Cosmetic Act, 1940
- Juvenile Justice (Care and Protection of Children) Act, 2000 and 2006.
- Maharashtra Protection of Commercial Sex Workers, Bill, 1994. Antiviral Therapy Guidelines for HIV infected Adults and Adolescents including Postexposure.
- Condom Promotion by SACS - Operational Guidelines
- Data Sharing Guidelines
- Guidelines for HIV Care and Treatment in Infants and Children, Nov 2006
- Guidelines for HIV Testing, March 2007
- Guidelines for Network of Indian Institutions for HIV/AIDS Research (NIHAR)[35]

[34] http://www.unicef.org/india/hivaids.html
[35] http://en.wikipedia.org/wiki/joint_united_nations_programme_on_HIV/AIDS

4.2.20 Role of Lawmakers in Battling the HIV/AIDS Epidemic

The scope of the Human Immunodeficiency Virus (HIV) pandemic has exceeded all expectations since the virus was discovered 24 years ago. Twenty-five million of the estimated 40 million HIV-positive individuals worldwide have already died. HIV/AIDS, more than any other health issue, is a primary cause of a country's development to stall since it affects people in the prime of their working lives and places an undue financial strain on the economy. Exactly half of the twenty countries (Bahamas, Belize, Botswana, Cameroon, Kenya, Lesotho, South Africa, Swaziland, Tanzania, and Zambia) that have suffered development reversals since 1990 are Commonwealth countries, according to the United Nations Development Programme's

(UNDP) 2004 Human Development Report. Given this, the Commonwealth Parliamentary Association convened in New Delhi, India, to set up an experienced Commonwealth Parliamentarian Study Group.[36] **4.2.21 Specific Sessions Encompassed**

v The responsibility and role of parliamentarians was explained by India's Minister of State for Statistics and Programme Implementation, Shri Oscar Fernandes, MP, who also provided a brief overview of the extent of the HIV epidemic in India. In order to reduce stigma and discrimination and to promote resource sharing among Commonwealth nations, he underlined the significance of open communication among legislators.

v worldwide response to HIV/AIDS An overview of India's HIV response was given in this presentation by Mr. Anand Tiwari, Advocacy Advisor and Officer-in-Charge, UNAIDS, with an emphasis on the nation's current HIV infection rates and noted trends of spread.

v The effects of HIV/AIDS on women and children Ms. Vandana Mahajan of UNIFEM gave a presentation on issues of poverty, reproductive rights, and violence against women, specifically in the Indian subcontinent. It was also discussed how gender equality should be prioritized, with an emphasis on electing more women to Congress.

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[36] http://c.ymcdn.com/sites/www/istr.org/resource/resmgr/working

v The economic toll that HIV/AIDS has taken I discussed this via video conference with Mr. Shan-tayanan Devarajan, the Chief Economist for the South Asia Region at the World Bank. Myths and realities were emphasized. He stressed the effects of HIV on GDP growth as well as other ramifications, especially the costs to the economy and the urgency of taking prompt, decisive action to lower these costs.[37]

4.2.22 What ought lawmakers to do?

Ensure that they are informed about HIV/AIDS, act as advocates for those who are impacted by the disease, and have an accepting attitude toward managing it. You can speak out against stigmatization, social taboos, and discrimination by bringing HIV/AIDS to light and busting myths and misconceptions about the condition. v Take care of the poverty issues that are closely related to HIV/AIDS. v Openly demonstrate their political resolve and commitment to eradicating HIV/AIDS. Encourage legislators and other interested parties to join and support national HIV/AIDS organizations. [124]

4.2.23 What ought to lawmakers do?

Encourage the dissemination of HIV/AIDS education to schoolchildren, members of Congress, constituents, and communities, particularly by ensuring that HIV education is included in the national curriculum. v Establish a permanent or select committee on HIV/AIDS and require the group to submit a report at least once a year.

Make certain that governments implement a multisectoral strategy to counteract the negative effects on the sustainability of social and economic development. Execute the mobilization of resources. Talk about gender-related issues such as the role of men and boys, women's empowerment, human trafficking and exploitation, and gender-based violence.[38]

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[37] http://c.ymcdn.com/sites/www.istr.org/resource/resmgr/working_papers_toronto/jamil.ishtiaq.pdf [124] www.cpqhg.org

[38] http://www.who.int/hiv/pub/idu/targetsetting/en/index.html [126] http://www.naco.nic.in

4.2.24 NAPCP stands for National Aids Prevention and Control Policy

For fifteen years, India has been experiencing an AIDS (Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus) epidemic. It has swiftly grown to rank among the country's most important public health concerns. Injecting drug users in the northeastern State of Manipur and commercial sex workers in Mumbai and Chennai were identified as the initial cases of HIV/AIDS. Since then, the disease has rapidly spread in the areas surrounding these epicenters; by 1996, AIDS cases in the country had been reported from Maharashtra, Tamil Nadu, and Manipur combined, accounting for 77% of cases, with Maharashtra reporting close to half of all cases. Though the officially reported cases of HIV infections and full-blown AIDS cases are only in the thousands, it was found that there is a significant discrepancy between the reported and estimated figures due to the lack of epidemiological data in many regions of the country. The most recent estimate puts the number of adults in the country who had HIV/AIDS in 2000 at 3.8 million. Still, compared to many other Asian countries, the country's overall prevalence is relatively low.[126]

4.2.25 Program Administration

Traditionally, the Ministry of Health and Family Welfare has been in charge of managing public health matters, such as the AIDS control initiative. Because of the disease's behavioral nature and major socioeconomic ramifications, it must be treated as a developmental issue that impacts many economic and social sectors of governmental and non-governmental activity. The involvement of Ministries such as Railways, Surface Transport, Heavy Industry, Steel, Coal, Youth Affairs & Sports, and other public sector organizations with sizable workforces is necessary because the disease is more likely to affect the economically productive segments of the population. The organized and unorganized sectors of the industry must come together to ensure the well-being of their workforce's productive segments. Ministries such as Social Justice & Empowerment, Women and Child Welfare, Human Resource Development, etc. should design and oversee the HIV/AIDS control programs within their respective sectoral jurisdictions.

These Ministries should provide strong financial and administrative support for these sectoral initiatives.[39]

4.2.26 Advocacy and Social Mobilization

In India, almost everyone uses print and electronic media to disseminate information. The remarkable rise in public awareness of HIV/AIDS can be partially attributed to the electronic media, which has disseminated this message all the way down to the village level. While the disease is generally understood, many people are still in the dark about certain aspects, such as the mode of transmission and ways to avoid infection, for example. Thus, there is a pressing need to create programs that prioritize interpersonal communication and are suitable for target groups such as women, migrant workers, children, students, and youth. The electronic media should create a well-coordinated media strategy in order to effectively disseminate information on all aspects of HIV/AIDS, including the promotion of positive cultural and social values like love, warmth, and affection within the family. Print media such as newspapers and magazines should be used for social mobilization efforts and information exchange in order to increase public awareness of prevention.[40]

4.2.27 Use of Condoms as a HIV/AIDS Prevention Measure

Condoms were previously marketed by the Family Welfare Program as a safe approach to population control. Since condom use is the only method of preventing HIV/AIDS through sexual contact, aside from complete abstinence, it has taken on special significance in the context of AIDS. The government feels that condom use should be encouraged for all sexually active individuals, especially those who participate in high-risk behavior, without regard to moral, ethical, or religious constraints. By means of social media marketing and a community-based distribution network, the government has established condom use as an intentional policy. The social marketing approach has led to a rise in the country's overall condom usage. Making sure condoms are accessible when

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[39] www.hsph.harvard.edu/population
[40] www.isec.ac.in/prc_abs17.pdf

and where they are needed is more crucial than ever. Hospitals, STD clinics, counseling services, assisted living facilities, and even private medical clinics ought to keep an adequate supply of condoms on hand for the benefit of their patients. Condoms should be easily available for use by sexually active individuals in public spaces, five-star hotels, major road and railroad intersections, neighborhood drug stores, etc. This will support the small family norm while also helping to achieve the dual goals of HIV prevention and control.[41]

4.2.28 Counseling

Counseling services for people with HIV/AIDS (PLWHAs) and suspected cases of HIV infection should be expanded in order to reach more people who need them. All hospitals, HIV testing centers, blood banks, STD clinics, and organizations started by PLWHAs should have counseling services manned by certified and trained counselors. The government has given these centers all the support they need to establish the infrastructure needed for them and to hire a large number of counselors to staff them. Offering PLWHAs the required monetary and non-monetary incentives will promote group counseling, which has been shown to be highly successful.[42]

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

The number of HIV-positive individuals in society will rise dramatically as the disease spreads across the country; these individuals may come from a variety of social and economic backgrounds. In addition to providing counseling before disclosing their HIV status, the government would seek to ensure these individuals' social and economic well-being by ensuring that (a) their right to privacy and other human rights were respected and (b) they received the necessary care and support in hospitals and the community. HIV-positive individuals ought to have equal access to the workforce and educational opportunities as the general public. HIV status should be kept secret and

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[41] http://www.hivlawandpolicy.org/resources/toolkit-scaling-hiv-related-legal-services-idlo-unaids-undp2009
[42] http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/hivtoolkit.aspx

http://www.idlo.int/Publications/HIVtoolkit.pdf

should not interfere with an individual's ability to get a job, keep a job, get married, or exercise other basic rights.[43]

4.2.30 Surveillance

Developing an appropriate surveillance system to assess the extent of HIV infections in the community is essential for selecting the most effective strategy for HIV/AIDS/STD prevention and management. The monitoring system is made up of:

v HIV Sentinel Surveillance: To track the trends of the epidemic, the government would enhance and broaden the current surveillance system's data collection on HIV infections in high-risk and low-risk populations in rural and urban areas.

v To determine the incidence of AIDS cases in the country, data will be collected from all hospitals with physicians who have received training and from a standard definition of an AIDS case in the Indian context. v STDs Surveillance: The institutional surveillance system of the National Venereal Disease Control Programme was put in place in the early 1950s, but it remained incomplete and patchy.

v Behavioral Sentinel Surveillance: The program will first employ behavioral sentinel surveillance on a pilot basis, and it will then be expanded as needed. Its goal is to evaluate how different risk groups within the population's behavior patterns are changing.[44]

4.2.31 Components of legal services

Social workers at the Legal Aid Clinics provide clients with basic legal information and referrals; they also serve as their first point of contact. The social worker might advise the client to make an appointment with the lawyer from the Legal Aid Clinic, law enforcement, or other legal aid providers. Legal advice: The lawyers provide legal advice, highlighting possible means of settling conflicts outside of court, such as Lok Adalat and alternative dispute resolution. Legal representation: Should it be required; the legal aid clinic will provide clients with ongoing support to settle conflicts through

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[43] http://www.who.int/hiv/pub/surveillance/en/
[44] http://www.hrln.org/hrln/hiv-aids.html

participation in ADR or Lok Adalat processes. Legal aid clinics usually suggest alternative dispute resolution (ADR) over formal court procedures. This not only saves money and time, but it also encourages confidentiality.[45]

4.2.32 Conclusion

NGOs are dependent on public donations, government support, and grants. However, relying on the government too much is not a good thing. NGOs will not lack donations from the public if they are known for their integrity, openness, and resultsdriven work cultures, as well as if they operate with a humane mindset. They must answer to society and be prepared for social audits at all times. However, the realization of human rights is the welfare state's ultimate objective. It is crucial that the government's governance and methods be in line with human rights, that the bureaucratic structure's actual work culture be in line with human rights, and that officials, officers, and employees carry out their duties in a humane manner. In a democratic country, the people's leaders have a unique role to play in accomplishing the welfare state's objectives. They have the obligation to lead the bureaucratic apparatus in accordance with the welfare state's objectives, manage to give the populace sufficient information, and exhibit a positive outlook.

[45] http://www.who.int/hiv/topics/vct/toolkit/components/policy/introduction/en/index4.html

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