

Supporting Community Action on AIDS in India

## CHAHA PROGRAMME ANNUAL REPORT 2008 - 09



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## Acknowledgements

The India HIV/AIDS Alliance is implementing the Global Fund Round 6 supported CHAHA programme in four states, Manipur, Maharashtra, Tamil Nadu and Andhra Pradesh. It is through the partners in these states that CHAHA programme has been able to reach out to children and families in both urban and rural areas that pose immense challenges.

The Alliance India is happy to acknowledge the noteworthy contribution that SR and SSR have made to greatly enhance the wider understanding on deepening programming efforts in relation to home and community-based care and support services for Children living with and affected by HIV in addition to a high level of performance orientation.

The SR - Alliance for AIDS Action (AAA), Tamilnadu Social Service Society (TASOSS), LEPRASociety, MAMTA-Health Institute for Mother and Child, Plan India, Palmyrah Workers Development Society (PWDS), Social Awareness Service Organisation (SASO), Vasavya Mahila Mandali (VMM) and Network of Maharashtra by People Living with HIV (NMP+) - have made an important contribution to the preparation of this report.

The Alliance India is thankful to the National AIDS Control Organisation (NACO) and State AIDS Control Society officials and staff at tertiary and district ART centres, and NGOs for their cooperation in steering the project ahead. We would like to thank the Global Fund for supporting the programme for addressing the need of the children living with and affected by HIV.

For more information on the International HIV/AIDS Alliance and its work in India, please visit our website on [www.aidsalliance.org](http://www.aidsalliance.org); and to access Alliance India's resources and publications, please visit its virtual resource centre – Setu - on [www.aidsallianceindia.net](http://www.aidsallianceindia.net), or write to:

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## The Alliance India

**T**he International HIV/AIDS Alliance is a global partnership of nationally-based organisations working to support community action on AIDS in developing countries. The national partners help local community groups and other non-government organisations to take action on AIDS, supported by technical expertise, policy work and fundraising carried out across the Alliance.

The vision of the Alliance is of a world in which people do not die of AIDS. This means a world where communities have brought HIV under control by preventing its transmission, and where they enjoy better health and higher quality of life through access to comprehensive HIV prevention, care, and support and treatment services.

Established in 1999, the India HIV/AIDS Alliance (or, Alliance India) comprises a Secretariat in New Delhi, five lead partner organisations (the Linking Organisations within the global Alliance) and their networks of over 100 community-based non-governmental organisations (NGOs) and community-based organisations (CBOs) across Andhra Pradesh, Tamil Nadu and Maharashtra states, and a state partner in Manipur. The Alliance's project office in Hyderabad was formally launched in April 2008 as the fifth lead partner (or Linking Organisation) in India.

The Alliance India has supported over 120 community-based projects through its NGO and CBO partners to prevent HIV infection; improve access to HIV treatment, care and support; and lessen the impact of HIV. The last including reducing stigma and discrimination, particularly among the most vulnerable and marginalised communities key to the epidemic – sex workers, men who have sex with men (MSM), injecting drug users (IDUs) and adults and children living with and/or affected by HIV.

Funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was awarded to the Alliance in July 2007, whereby the partnership in India has been broadened to include two new project-based lead partner relationships with two external organisations and their networks of implementing NGO partners.

# Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti Retroviral Therapy
CAA	Children Affected by AIDS
CBO	Community Based Organisation
CLHIV	Children Living with HIV
DAPCU	District AIDS Prevention and Control Units
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCBCS	Home and Community-Based Care and Support Programme
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IGP	Income Generation Programme
MSLM	Mutual Sharing and Learning Meeting
MSM	Men having Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NMP+	Network of Maharashtra People Living with HIV
OI	Opportunistic Infection
ORW	Outreach Worker
PLHIV	People Living with HIV
PR	Principal Recipient
SDA	Service Delivery Area
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SSR	Sub Sub-Recipient

## A message from the Country Director

It is a pleasure to introduce this 2008 – 2009 annual report for CHAHA. On the one hand it is uplifting, as it tells of an impressive and rapid scale up of services to thousands of Children living with and affected by HIV, who now have access to essential support. On the other hand it is sobering, as it narrates the challenges still to be addressed.

Any programme that attempts to mitigate the impact of HIV on families, as CHAHA does, witnesses the ways that HIV reduces household income through the death of wage earners, through an inability to work, through the extra expenses required for food and medicines. The report shows how CHAHA seeks to address this, in the short term through nutritional and emergency support, and longer term through income generation support. Yet CHAHA is not a permanent feature in the social welfare landscape, and in part its success must to be judged according to how well it facilitates linking families to more sustainable support options, such as government schemes. This is now a priority for the programme.

Another priority is that CHAHA should be a programme of learning, about what works best for children and their families, and about the obstacles that need to be overcome to ensure better quality care and support. The operational research this year into access to ART for children revealed that stigma and discrimination continue to be the greatest deterrents that prevent children and their families from testing for HIV or accessing ART. CHAHA can and does make significant contributions to reducing stigma and discrimination in the communities it which it operates, but the scale of this challenge requires interventions beyond CHAHA's scope.

What is most striking about this report is the numbers. Over 15 000 children have joined the programme this year. In many cases, joining the programme is a turning point for children and their families, when exclusion is broken and new opportunities for hope emerge. Many of these stories have been captured in photographs and case studies. They are stories worth telling, with courageous families and inspiring outreach workers. It is perhaps above all, the outreach workers that should be thanked and congratulated for the lives that have been changed through CHAHA, and will continue to be changed as we continue our scale up in the years to come.

I would like to take this opportunity to thank the Global Fund for its generous support.

**Alexander Matheou**  
Director  
India HIV/AIDS Alliance

## The Need

In 2007, the National AIDS Control Organisation (NACO), India, estimated the national HIV prevalence of 0.36 percent through its sentinel surveillance. Approximately 2.5 million people were estimated to be living with HIV mainly. The maximum concentration of the epidemic was observed to be in about 200 districts that are mainly located in six states – Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland. These states also contribute about 64% of all people living with HIV (PLHIV) in India. NACO has also

estimated that about 70,000 children below the age of 15 years are living with HIV and more than 21,000 children are acquiring the infection through parent-to-child transmission. In addition to children living with HIV (CLHIV),

there are children who are directly affected by HIV (CAA) either because of HIV infection in the family and death of their parents due to HIV related illnesses. Some AIDS orphans are adopted by their grandparents or extended families but most of them lack any support. Children headed households are becoming common in many areas where the older children have to shoulder the responsibilities of their siblings and themselves.

HIV and AIDS impact children in multiple ways. It has an adverse impact on their health, especially among those living with HIV. They are unable to continue education due to stigma

and discrimination, the need to take care of the ailing parents or the necessity of taking on economic responsibilities. They are also unable to access the health services and various welfare schemes.

For a long time, care and support for CLHIV and CAA had not received the necessary attention from policy makers and implementers of HIV and AIDS programmes. Until a couple of years ago, the few the responses made were inadequate, inappropriate and often inaccessible. This was especially true for providing HIV related services to the CLHIV such as access to paediatric anti-retroviral drugs (ART), management and prophylaxis of opportunistic infections (OIs) and other health services such as vaccination, nutritional supplements. The problems faced by the children, including the CAA are compounded by the widespread stigma and discrimination.

The National AIDS Control Programme Phase III (NACP III) recognised the unmet needs of the CLHIV and CAA and gave the due importance to scaling up of child focussed services. The strategies suggested by NACP III were early diagnosis and treatment, comprehensive guidelines for paediatric HIV care, enhancing capacity of counsellors for counselling CLHIV and CAA, linkages with social sector programmes for accessing social support for CLHIV, outreach and transportation subsidies to access ART, follow-up to promote treatment adherence, nutritional, educational and skill development support and enforcing minimum standards of care and protection in institutional, foster care and community-based care and support for the children.



# CHAHA - Alliance India's Response to the Specific Needs of Children

In India, the Alliance is considered to be a pioneer in providing home based care and support to PLHIV and their families. Its first response to the specific and growing needs of children living with and/or affected by HIV and AIDS was in 2000, when it initiated an Abbott Fund Supported child centred Home and Community Based Care and Support (HCBCS) programme. Alliance India had implemented this project along with its NGO partners in the states of Tamil Nadu, Andhra Pradesh and Delhi. Experience from this project and the findings of a baseline survey conducted during 2007 had helped Alliance India to design the CHAHA programme, keeping in mind the strategic priorities of NACP III. CHAHA, which means "a wish" in Hindi, was designed to mitigate the adverse impact of HIV and AIDS on children. It receives funding support from Round 6 of the Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM). Alliance India, which is the civil society Principal Recipient (PR) for the project, has been implementing this project in partnership with a consortium of 9 Sub-Recipients (SR), 54 Sub-Sub-Recipients (SSR). The project was divided into two phase – Phase I of two years duration and Phase II of three years duration.

When the project was initiated, there were 8 SRs. During the 8th quarter (April-June 2009), Catholic Relief Services (CRS), one of the original eight SR indicated their inability to continue with the CHAHA programme as a SR. A vigorous selection process of potential partners was therefore undertaken to identify additional SRs to replace CRS in Tamil Nadu and Maharashtra. TASSOS from Tamil Nadu and Maharashtra Network of People Living with HIV (NMP+) were identified as SRs for their respective states.

## Overview of the project

The project was designed for five years as an expanded child-centred HCBCS to provide care and support to 64,000 children living with HIV and AIDS (CLHIV), children affected by HIV and AIDS (CAA) and their families, especially the women-headed families, residing in 41 districts in the states of Maharashtra, Andhra Pradesh, Tamil Nadu and Manipur. The project also aimed to work closely with various stakeholders and government ministries to explore options of ensuring that the children remained with their parents or with extended families.

Alliance gives significant emphasis on a community-driven response to HIV and believes that family involvement and active engagement and leadership of the community is a prerequisite for any HIV intervention. This is why CHAHA adopts a holistic approach to respond to the needs of the CLHIV/CAA and provides integrated services for the child and a member of the family, which is taken as an integral part of the community.

The three main approaches of the project for providing direct services to children living with and/or affected by HIV and AIDS were to:

- a. Create a supportive environment through community mobilisation in all settings (health, social and legal) for stigma reduction.



- b. Strengthening and capacity building of NGOs and CBOs.
- c. Strengthening information systems and conducting operational research.

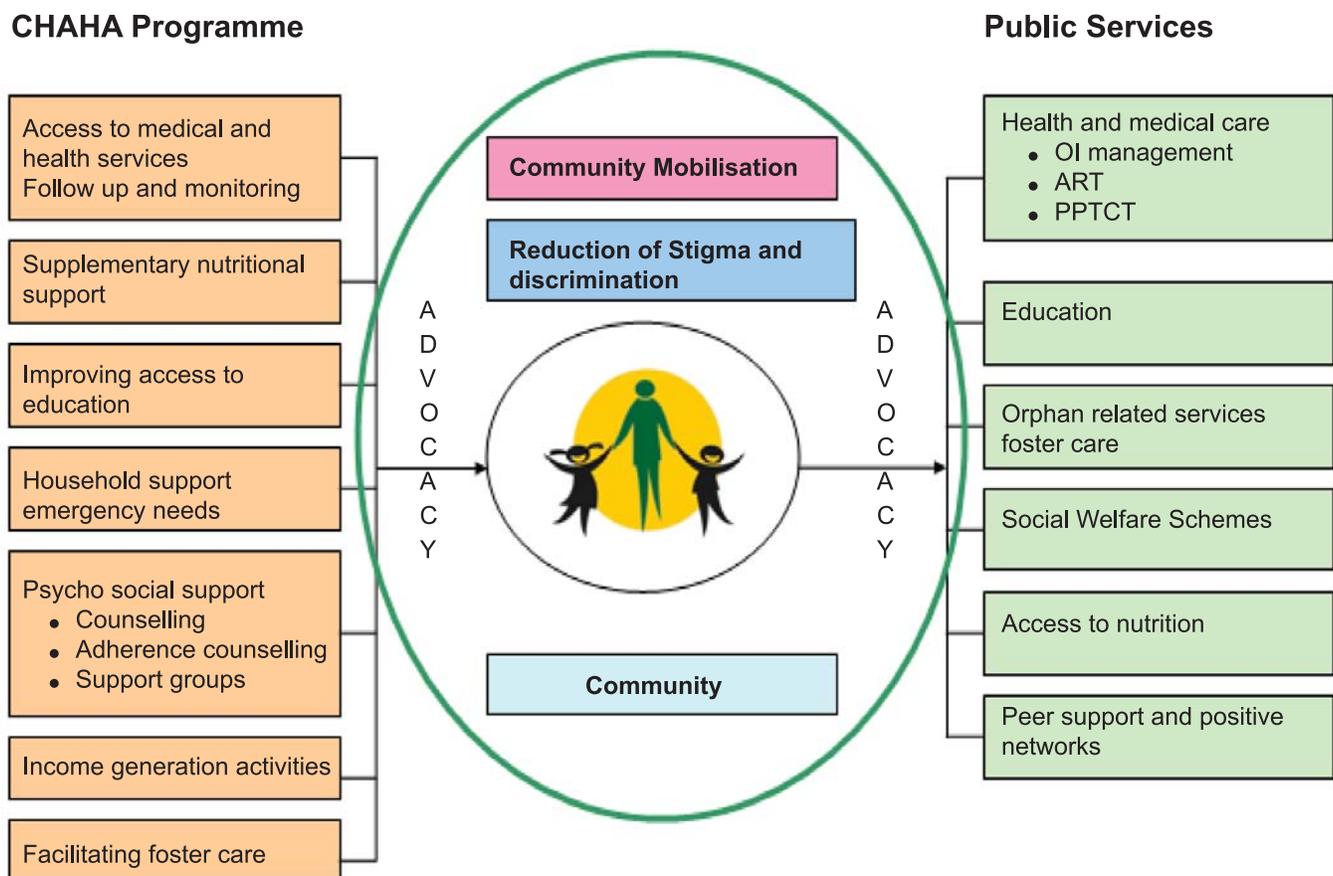
### Implementation strategies – Phase I

Since its inception, CHAHA has kept the affected families at the centre and as a part of the community in order to increase effectiveness of various services essential for mitigating the adverse impacts of HIV and AIDS and create a conducive, non-stigmatised and supportive environment for children and families. CHAHA provides a comprehensive package of care and support services to the affected children

and families through four main service delivery areas (SDA). These include:

- SDA1: To improve care and support services to children living with and/or affected by HIV and AIDS.
- SDA2: To create a supportive environment for reducing the stigma and discrimination.
- SDA3: To create a supportive environment for strengthening of civil society and institutional capacity building
- SDA4: Information systems and operational research

**Figure 1: Comprehensive framework of services provided by CHAHA**



The comprehensive package of services provided by CHAHA is as shown in Figure 1.

## Changes in the programme

Certain compelling circumstances and the need to provide quality of services necessitated three major changes in the programme:

1. Reducing the duration of Phase I of the project from 24 months to 19 months and reducing the duration of Phase II of the project from 36 months to 24 months. There was no change in the target of total number of children to be reached. The quarterly targets were however modified as per the modified project duration.
2. Increasing the number of outreach workers in Phase II of the project in order to ensure quality of services despite a dramatic increase in the targets for each quarter.
3. Inducting community based volunteers to strengthen the quality of service delivery.

## Reduction in the duration of the project

The first phase of the project, which started in June 2007, was scheduled to end in June 2009 but certain unforeseen circumstances

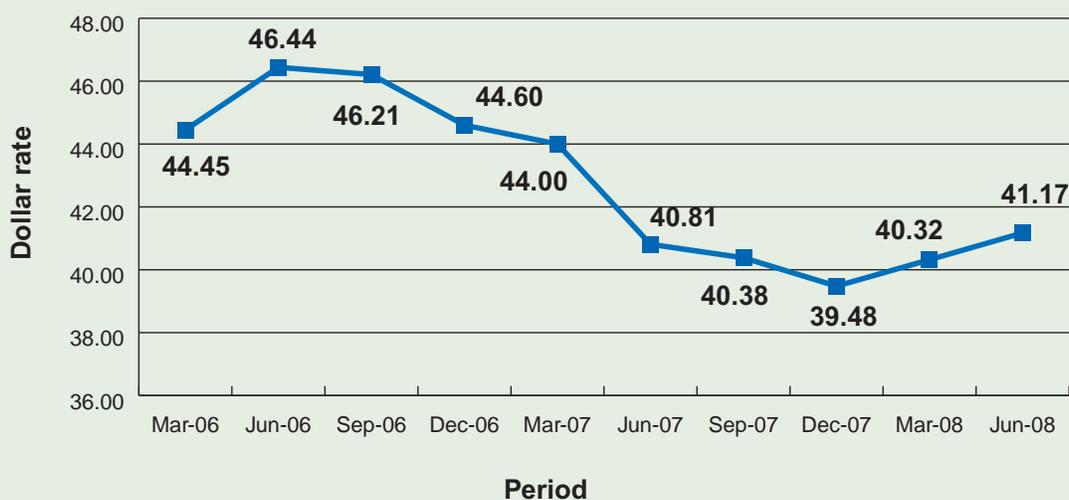
necessitated that Alliance India make a grant acceleration request for closure of Phase I one of the project in January 2009 without reducing the targets, which was granted by GFATM. The second phase of the project, therefore, started in February 2009 and is scheduled to end in January 2011 instead of June 2012. The two main issues and justification for the grant acceleration request were:

1. Depreciation of the US dollar against Indian Rupees
2. Need for increased allocation of budget for (a) salary of implementing SSR staff, (b) travel of SSR staff and (c) strengthening child support groups

Depreciation of the US dollar against Indian Rupees:

When the proposal was developed, the exchange rate at the time of proposal development was at INR 46.44 to a US Dollar. Keeping in mind the normal fluctuations, the rate was pegged at INR 45 to a US Dollar. However, within the first six months of the project that commenced in June 2007, the US Dollar depreciated and the exchange rate fell to 39.48 in December 2007 (Figure 2).

Figure 2: Depreciation of Dollars against Indian Rupees





The Dollar depreciation trend indicated that the Phase I of the project of Global Fund Round 6 would not have funds to last till the end of the 24-months project cycle. The funds were expected to dry up by January 2009, and the project duration was therefore sought to be reduced.

### Need for increased budget allocation

Salary of the implementing staff: The proposal for CHAHA programme was developed in early 2006 and the salary structure was planned according to the then national guidelines. However, by the time of starting the project in June 2007, the national guidelines had changed due to the implementation of NACP-III. There was a significant gap between the salary structure that was originally proposed and the structure that was recommended by the national guidelines. This difference made it difficult to both retain trained staff and recruit new competent staff for the CHAHA programme by all three – the PR, the SR and the SSR. Loss of skilled manpower would have an adverse impact on the outcome of the project. For example, the staff leaving the SSR would take along with them the experience and beneficiaries-related retrospective issues

that have a major impact on the relationship between the service providers and the beneficiaries.

Additional funds for travel of SSR staff: The beneficiaries – children and their families – were living in widespread areas across the districts of intervention. The implementing staff therefore needed to travel extensively to provide services to the beneficiaries. Between the time of developing the proposal and starting the project, the cost of travel had increased considerably and was inadequate for the necessary travel. The number of children reached through the project was expected to increase dramatically during each quarter, which again demanded increased travel cost by SSR staff.

Additional funds for Child support groups: Sharing experiences and mutual support by the children living with and/or affected by HIV and AIDS and their parents through Child support groups has been observed to be an effective activity and strategy. It was observed that the funds allocated for such group meetings were inadequate to introduce and sustain a wide range of child-centric group activities such as the use of arts and crafts, providing life skills education, etc.

The following changes in the unit costing of direct services, as shown in Table 1 became effective in phase II of the project.

**Table 1: Changes in the unit costing of direct services**

	Type of service	Phase-I	Phase-II	Variance
1	Supplementary nutritional Support	900	1304	404
2	Basic Household support	2610	2980	370
3	Educational Support	1125	1328	203
4	Income Generation Support	1875	1875	0
5	Travel for OI	169	169	0
6	Support Group Per Annum	200	2700	2500

## Increasing the number of outreach workers

One of the challenges faced by the project in Phase I was to provide quality of services by devoting the necessary time for children and the families. There was a dramatic increase in the number of beneficiaries reached in Year 2. About double the numbers of children were recruited into the programme, and for most indicators, the targets achieved were twice those achieved in Year 1. On some indicators the increase has been more than 3 times. Providing quality of services to an increased number of children offered two main challenges:

- Identifying more children and families in need of project support; and
- Providing quality services as per the guidelines developed.

The project partners had also realised that the demand for services was more extensive than what was envisaged during the proposal development. In Phase I, most beneficiaries were identified by the outreach workers (ORW) whereas in Phase II, an increasing number of children and their families were seeking services on their own. In order to meet the increasing demand in terms of targets and quality of services, the ratio of children to ORW was changed from 75:1 to 60:1. Increase in the number of ORW also meant increase in capacity building initiatives and increase in travel allowance. The number of ORWs is planned to be increased in three phases – at the inception of Phase II, six months later and at the beginning of second year of Phase II. This increase corresponds with the increase in the targets.

## Introduction of community based volunteers

Assistant Project Coordinators and Community volunteers have been recruited in Phase II of

the programme with an aim to enhance the reach, network and level of community participation.

The Assistant Project Coordinator is expected to support the Project Coordinator at SSR level in managing human resources, advocacy and computerized management information systems. PLHIV, who have been successfully able to live a positive and healthy life are preferred as Community volunteers. They act as the drivers of change at community level and increase the interface between the programme and the general community. They also assist the ORW in service delivery and provide critical feedback from the community. The strategy to recruit Community volunteers is the outcome of operational research done in Phase I on barriers to access ART by children and successful practices of working with children.

The targets of CHAHA project are shown in Figure 3.

## Key achievements during Year 1

The programme was able to achieve over 98% of the target on every indicator and was able



Figure 3: Targets of CHAHA project



to train more NGO staff as per the needs of the situation. It was also able to attract more members of the community to the sensitisation meetings and meet the increased demand for the child support groups. These factors had helped strengthen the case that a more rapid up scaling would be feasible and CCM and GFATM has encouraged Alliance India to try and achieve the targets which were set for a duration of 60 months within a period of 43 months. The key achievements during the first year of the project from June 2007 – June 2008 were as summarised in Table 2

## Achievements during Year 2

The Year 2 (July 2008 – June 2009) activities includes a period where the programme was being implemented as per the strategies of Phase I (during July 2008 to January 2009) and as per the strategies of Phase II (during February – June 2009).

## Overall performance of the programme

During the second year of the programme, the learning and experiences gained from the implementation of Phase I of the programme helped modify key strategies for Phase II of the programme. Because of the reduction in the programme duration, there was a rapid increase in targets commencing from the end of Phase 1 and greater emphasis was laid on quality of service delivery and community ownership by increasing the number of ORWs, appointing Assistant Project Coordinators and recruiting Community Volunteers. There was also a shift from service delivery model to developmental model. Two tools – “Voices of the community” and CHAHA programme Quality Assurance and Quality Improvement checklist have been developed to ensure quality.

The programme continued to offer comprehensive package of services, especially need-based home and community care and

**Table 2: Key targets and achievements during Year 1 (June 2007-June 2008)**

Indicators	Target	Achieved	% Achieved
Number of CLHIV and CAA under 18 years of age benefiting from a minimum package of care and support services	8,333	8,253	99
Number of CLHIV and CAA receiving nutritional services including nutritional counselling and demonstration services	3,333	3,479	104
Number of households of CLHIV and CAA covered by basic support	4,167	4,484	108
Number of children referred for paediatrics ART to a healthcare institution	417	409	98
Number of CLHIV and CAA provided with educational support and/or vocational training	1,333	1,427	107
Number of households provided income generation support	833	862	103
Number of Children support groups formed	105	126	120
Number of sensitisation meetings held in communities	350	389	111
Number of participants attended the sensitisation meetings held in communities	3,500	3,991	114
Number of NGO/CBO staff trained	250	637	255

support services. There was an increased thrust on establishing and sustaining successful linkages, individual child and family case management and advocacy.

Towards the end of the year, most of the 2,500 CLHIV who were earlier supported under the Clinton Foundation CHAI programme were enrolled into the CHAHA programme. This was because of the closure of Clinton Foundation programme in July 2009. These children reside in 12 districts of Andhra Pradesh, Maharashtra and Manipur, which is a part of the CHAHA coverage area. Some of the Clinton Foundation partners are also CHAHA partners, which makes it easier for service delivery as the beneficiaries have already developed a rapport with the implementing partners.

The total number of children enrolled in CHAHA programme during Year II is 15,636. The total number of children enrolled during the two years of programme implementation is 23,889 (Table 3).

The percentage of CLHIV enrolled had dropped from 29.8% during June-September 2007 (beginning of Year 1) to 12.4 during October-December 2008 (second quarter of Year 2). Modified strategies adopted by CHAHA programme from February 2009 has resulted

**Figure 4: Quarterly registration of CLHIV and CAA**



in an increase in the percentage of enrolment of CLHIV to 16.9 during the last quarter of Year 2 (April – June 2009), as shown in Figure 4.

Ratio of orphaned CLHIV/CAA attending school to non-orphaned non-CLHIV/CAA aged 10-14 years is an impact indicator that is being tracked in CHAHA programme. It has shown an increase from 90.1% in baseline survey in December 2007 to 96.2% in midline survey at the beginning of Phase II. This is well above the target.

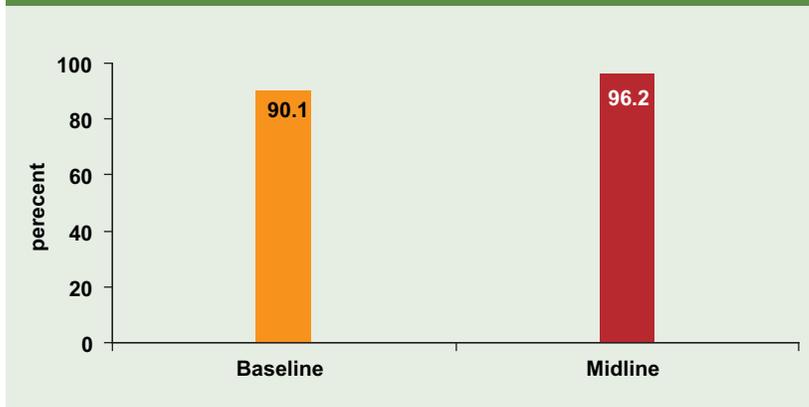
#### Targets and achievements for each indicator during Year 2

The percentage of targets achieved was more than 100% for eight of the ten targets except for number of CLHIV/CAA receiving a comprehensive package of care and support services (99.54%) and number of

**Table 3: Number of CLHIV and CAA enrolled in CHAHA programme**

Period	CAA	CLHIV	Total	Cumulative
<b>Year 1</b>				
June-Sept 07	534	227	761	761
Oct-Dec 07	1695	474	2169	2930
Jan-March 08	2126	467	2593	5523
April-June 08	2299	431	2730	8253
<b>Year 2</b>				
July-Sep 08	2730	507	3237	11490
Oct-Dec 08	2569	364	2933	14423
Jan-March 09	3339	643	3982	18405
April-June 09	4555	929	5484	23889
Total (June 07-June 09)	19847	4042	23889	

**Figure 5: Ratio of orphaned CLHIV/CAA attending school to non-orphaned non-CLHIV/CAA aged 10-14 years**



children referred for ART (86%). The greater emphasis on increasing community ownership was indicated by 131.46% achievement in number of participants attending community based sensitisation meetings and 140.53% achievement for number of Children support groups formed (Table 4).

### Service Delivery Area I: To improve care and support services for CLHIV and CAA

#### Indicator 1 – Number of CLHIV and CAA and their families receiving a comprehensive package of care and support:

The programme has been laying greater emphasis on referral linkages and community networks, which are becoming increasingly the main source of information and contact point to reach the children and their families. The selection of children is based on the assessment of vulnerabilities and needs of the child and the family through discussions and observations. CHAHA programme has also been able to ensure that there is no gender inequality in enrollment of the children. Almost 49% of the children registered have been girls.

A total of 15,636 children were enrolled in the programme during Year II. The highest enrolment was during April-June 2009 at 5,484 (Figure 6) indicating that the newer strategies

**Table 4: Targets and achievements for the indicators of CHAHA Programme (July 2008-June 2009)**

Indicator description	Achievement during						Total achieved	Target	% achieved
	Year 1 (June 07-Jun 08)	July -Sep 08	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09	Year 2 (July 08-Jun 09)			
No. of (CLHA and CAA) benefiting from a minimum package of care and support services	8253	3,237	2,933	3,982	5,484	15,636	23,889	24,000	99.54
No. of CLHA and CAA receiving nutritional services	3479	1,301	1,242	1,604	2,179	6,326	9,805	9,600	102.14
No. of households of receiving emergency household support	4484	1,670	1,495	2,004	2,764	7,933	12,417	12,000	103.48
No. of children referred for paediatric ART	409	115	132	190	186	623	1,032	1,200	86.00
No. of CLHA and CAA provided with educational support and/or vocational training	1427	545	494	417	1,145	2,601	4,028	3,862	104.30
No. of households provided with income generation support	862	288	322	387	545	1,542	2,404	2,400	100.17
No. of Children support groups formed	126	46	53	134	64	297	423	301	140.53
No. of sensitisation meetings held in communities	389	168	219	310	328	1,025	1,414	1,330	106.32
No. of participants attended the sensitisation meetings held in communities	3991	2,168	2,896	4,350	4,079	13,493	17,484	13,300	131.46
No. of NGO/CBO staff trained	637	0	0	781	489	1,270	1,907	2,003	95.21

of appointing additional ORWs and recruiting Community volunteers, and increase in number of programme staff trained have been successful. Although the targets for each quarter during Year 2 have been dramatically increased and the information of the new targets was only available to the SSRs towards the end of 2008, the achievement has been 99.54% for this indicator, which demonstrates the programme's ability to meet the desired target even in a shorter duration of programme implementation.

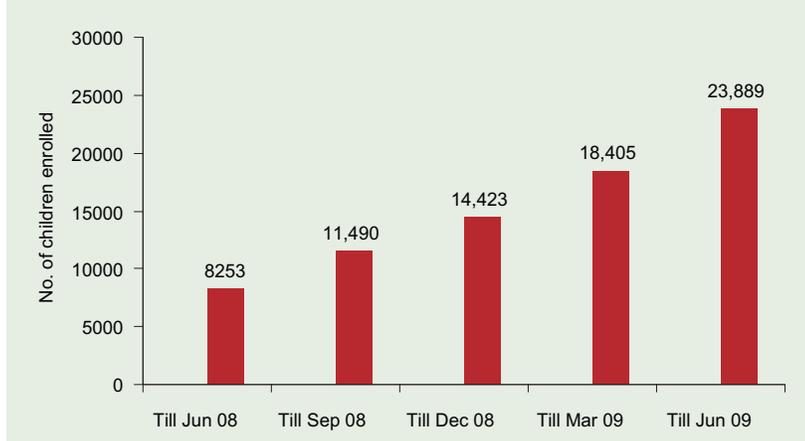
**Indicator 2 – Number of CLHIV and CAA receiving nutritional support:**

Supplementary nutrition is provided under the programme according to the need of the children through direct support from the project and also through linkages and networking with various schemes of government departments, individual donors, community groups, and organisations such as The Lions Club, Rotary International and other NGOs. Nutritious food preparation demonstration is done in the community using locally available food materials such as pulses, cereals and ready-made health mix in order to make it easier for the families to adopt it regularly. The families are also actively linked to more sustainable resources such as Integrated Child Development Services (ICDS) and Midday meals programme. In the state of Tamil Nadu, practical demonstration of nutritive preparation and setting up of kitchen gardens was done with support from ICDS staff.

Nutritional support provided at a frequency mutually agreed upon by the ORW and the family. The ORWs assess the utilization of nutritional services during follow-up visits. In Year 2, efforts were made to mobilise the general community to provide additional support to these families. In Phase-II, growth monitoring of each registered child was intensified to evaluate the impact of nutritional support services.

A total of 6,326 children had received nutritional services including nutritional counselling and demonstration services during the second

**Figure 6: No. of CLHIV/CAA receiving minimum package of care and support services**



year of the programme. The total achievement was 102.14% (Figure 7). The main reason for the achievement exceeding the targets by about 2% is an increased need and demand within the community for nutritional support.

**Indicator 3 – Number of households receiving emergency support:**

This is the most flexible component of the programme and is provided to a family based on the emergency need. It is mainly provided to those families where the caregiver is sick and unable to work, orphans living with grandparents and children of widows. The type of support ranges from meeting the cost of medicines, utensils, clothes, travel for CD4 testing or to ART centre, house repairs, roof sheets and water filters.

**Figure 7: No. of CLHIV/CAA receiving nutritional support**



*Zahira (name changed), a 12 year-old daughter of HIV positive parents, radiates ample joy when she is with the friends and books at school. Currently studying in Class VII in Hyderabad, Andhra Pradesh, Zahira has spent precious years of her young life away from school. Her father, an auto driver, abandoned his home maker wife and two children when he learned about their HIV status. He is currently remarried and visits the children only occasionally. He is however unable to support them financially. Initially, Zahira's grandmother and uncle initially paid for her and her younger brother's education. This was before the mother began to fall sick frequently. Increasing medical bills and the family's meagre resources led to the young children's withdrawal from the school. When an ORW of Hyderabad Leprosy Control and Health Society (HLCHS), the SSR working in the area, identified the family for enrolment into the CHAHA programme, the first step towards the arduous journey of building a better future for Zahira and her brother was taken. Zahira's mother was linked to the ART centre at Osmania Hospital where she was put on therapy because of low CD4 count. The counsellor of HLCHS counselled Zahira's mother on treatment adherence and living a positive life. The mother was also motivated to enrol the two children into a school once again by financing their monthly fees and books.*

*During the follow-up visits, the ORW realised that the mother was responding to the treatment slowly and the family needed additional support to prevent frequent episodes of opportunistic infections. The family was therefore provided a water filter, fan, mosquito net and blanket under the emergency support. The mother's health continued to improve, and yet, contrary to the expectations of the CHAHA team, Zahira and her brother were withdrawn from the school once again because of lack of adequate income in the family. After discussions with the mother, the NGO provided her support to buy a sewing machine. Today, Zahira's mother earns about INR 1,000 every month. Zahira and her brother are happy to be with the friends and books at school. They are equally happy to return home in the evening because they find their mother smiling after a long time.*

During Year 2 of the programme, emergency household support was provided to 7,933 children (Figure 8). The total achievement during the two years was 103.48% mainly because of an increased demand from the community.

#### **Indicator 4 – Number of children referred for paediatric ART:**

The ORWs continuously motivate families and children to undergo HIV test in the nearest Integrated Counselling and Testing Centre (ICTC). They also do regular follow-up for all the children and their family members who have tested positive. The main thrust during follow-up is on the health status, registration at the ART centre, receiving ART and promoting adherence. The ORWs also provide continued education to the family members and care givers on various issues related to living with HIV, treatment, management of OIs and their prophylaxis, etc. They also provide timely support for travel to various health centres, if necessary, so that there is increased access to, and increased utilisation of services. All HIV positive mothers were encouraged and supported for getting all their children tested. This was one of the reasons for increase in the percentage of CLHIV being enrolled in the last two quarters of Year 2.

A total of 623 children were referred for

**Figure 8: Number of households receiving emergency support**



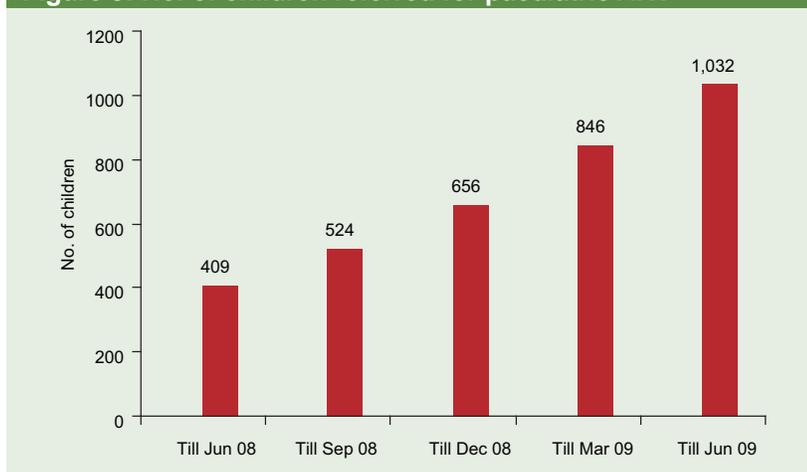
paediatric ART during the second year of the programme (Figure 9). The total achievement was 89% of the targets. The low achievement was attributed to higher CD4 count among a large number of enrolled children who therefore did not need ART.

**Indicator 5 – Number of children receiving educational support and/or vocational training:** CHAHA programme gives extra emphasis on the continuing education of the children. The disruption in the continuity of education is addressed by overcoming barriers that inhibit children from attending school, by addressing the issues at various forums and through innovative approaches. Children's education needs are identified through routine home visits. Dropouts are readmitted in the schools and issues at the schools are addressed by sensitising the school staff on the special needs of CLHIV and on eliminating stigma and discrimination. The ORWs also arrange for scholarships, discounts and fee waivers wherever necessary and possible. Support is also provided for paying school fees, tuition fees, course fees, uniforms, books, getting bus passes, etc. Utilisation of these supports is monitored during regular follow up.

During the second year of the programme, 4,028 children have been given educational support (Figure 10). There was a dramatic increase in the achievement during the last quarter of Year 2, which was mainly attributed to an increased demand from the community. Strengthening of outreach activities and active involvement of Community volunteers had also helped provide services to larger number of children. The total achievement till June 2009 was 104.3%.

**Indicator 6: Number of households receiving income generation support:** Income generation support (IGP) has been given to the more needy families with an aim to increase their livelihood options. Financial support has been given for setting up petty shops, provision shops, vegetable shops, tailoring units or flower

**Figure 9: No. of children referred for paediatric ART**



stalls, buying sewing machines, iron boxes, starting Tiffin centres, making beedi, retailing fodder for animals or fancy items, making leaf plates, salt vending, jute making, buying grass etc. Since the inception of the CHAHA programme, the NGOs have been aspiring to strengthen this component further by setting up a revolving fund. This has been possible for some of the partners by the end of Year 2. Several recipients of the IGP support have begun to repay the money, which has helped set up the revolving funds. Through this fund, a larger number of beneficiaries are expected to be given financial support for various income generation options in the subsequent years of

**Figure 10: No. of children receiving educational support**



the programme. The SSR staff are taking great care in the selection of the recipients, and in providing the handholding support needed to make the initiative withstand the early teething problems faced by the beneficiaries.

The number of households that received income generation support during the second year of the programme was 1,542 (Figure 11). The achievement was higher in the last quarter as compared to the previous quarters, which was yet another indicator of the increased acceptance and utilisation of services.

**Indicator 7 – Number of Children support groups formed:**

Children support groups have been set up for timely psycho-social support and to facilitate overall development of the children. These groups allow the children to share and express their feelings and learn from each other. The ORWs and counsellors organise regular Children support group meetings and train the children in personal hygiene and provide information on education, career options, etc. They also engage the students in a wide range of child-friendly activities such as singing songs, story-telling drawing, games, role-plays, etc. The counsellors provided individual, family and group counselling to enhance coping and develop a positive attitude towards life. Life skills education has been included in the

support group meetings which has helped reduced isolation and help the children bond with each other.

During the second year, 297 Children support groups have been formed (Figure 12). The total achievement till June 2009 was 140.53%. Several partners, especially in Maharashtra, had found it difficult to motivate a large number of enrolled children to participate in these support group meetings because of distant locations. They therefore felt compelled to set up additional Children support groups in each locality. This had led to the achievement exceeding 100% target.

**Service Delivery Area 2: Supportive environment for reduction of stigma and discrimination**

**Indicator 8 – Number of sensitisation meetings held:**

Sensitization meetings have been organised in various mandals, with PHC medical officers and government functionaries. Linkages with various departments at the district level have been strengthened through sensitisation meetings with panchayats, Block Development Officers and district education department. Linkages with health services have been strengthened by sensitising the district hospital superintendent, nodal officer of the ART Centre, district medical and health officer, and all levels of health care providers at care and support centres, ICTCs and PPTCTs. As a result of these sensitisation initiatives, an increasing number of children are being successfully linked to the government schemes and services on a regular basis. Another successful initiative has been working with the Children Welfare Committees at the district level. They are increasingly becoming aware of the CHAHA programme and by the end of the second year have begun to actively work in partnership with the NGO partners to work towards the common goal of addressing issues of children affected by HIV. In some case they have also supplemented CHAHA

**Figure 11: No. of households receiving income generation support**



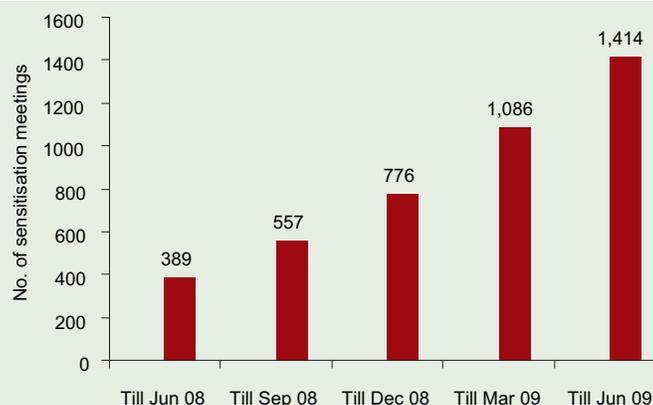
**Figure 12: No. of Children support groups formed**



programme's supply of nutrition to children and families in need.

The total number of sensitisation meetings held at community level during the second year was 1,025 (Figure 13). The achievement has shown an increasing trend during the four quarters of the second year. The number of meetings held during the last quarter was almost equal to the number of meetings held in the first year. This indicates an increased presence

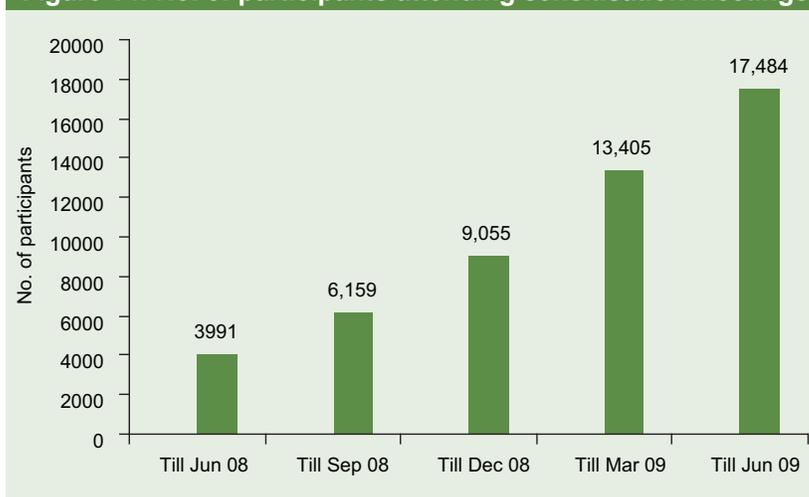
**Figure 13: No. of sensitisation meetings held at community level**



and acceptance of ORWs and Community volunteers as well as an increased focus on community sensitisation to reduce stigma and discrimination.

**Indicator 9 – Number of participants in sensitization programmes:** During the last two quarters of the second year, larger number of participants had begun to attend the sensitization meetings as compared to the first year. Overall, more than three times the

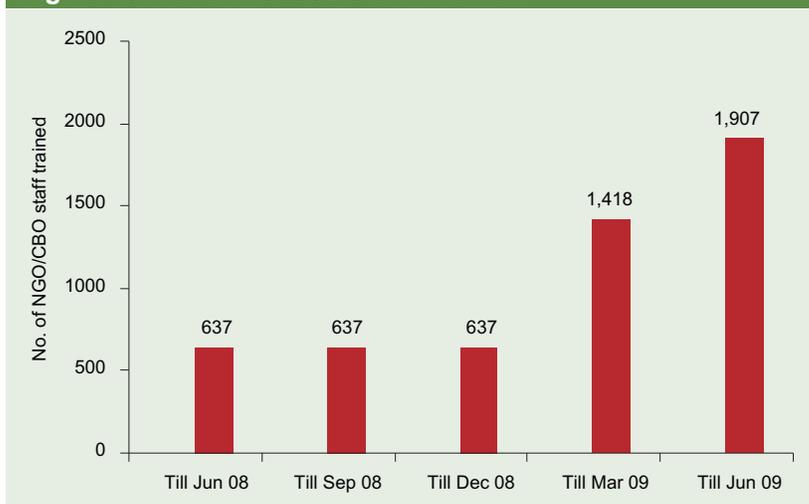
*Mohan and Kavitha (names changed), teenager siblings who reside in Theni urban block in the state of Tamil Nadu have finally found a place to live in, after experiencing immense discrimination from the family. Their father passed a few years ago and their mother sent them to a boarding school hoping to give them a secure and brighter future. Sadly, their mother passed away soon after. When the children returned home during their holidays, they realised they had nowhere to go. They first went to their mother's house but were turned away. The same experience was repeated when they went to their father's house. At this critical time, a kindly neighbour took them in for a few days till they sorted out their lives. When the CHAHA programme outreach worker heard about the children, she tried to counsel the fathers' brother but he blamed the mother for the children's problems and refused to help. The ORW subsequently took the children to the mothers' family but they too refused to support the children despite being wealthy. As a last resort, the outreach worker sought help from a benevolent community leader and asked him to resolve the issue. Initially, the community leader asked the children to live with him till their problems were sorted out. The community leader found that their father owned some land but his family were not willing to give it to the children. The community leader negotiated with the fathers' family and got this land handed over to the children and supported them in constructing a small hut on the inherited land. He provided them with some basic needs and identified an elderly lady living alone who could stay with the children. After several visits and discussions in community by the community leader and the outreach worker, the larger community is now willing to interact with the kids although they are not yet providing any support. Kavitha, now 16 years of age, has found a job that pays about INR 1100 a month. She gave up her studies in order to work and support her brother to complete his education. A permanent place to stay and ability to afford their minimum needs makes Kavitha feel secure. Her younger brother, Mohan, is finally able to focus on studies and pave way for a better future.*

**Figure 14: No. of participants attending sensitisation meetings**

number of participants attended these meetings in the second year as compared to the first year (Figure 14). The overall target achievement for this indicator is substantially higher at 131.46%, indicating an increased community involvement and ownership and creation of an enabling environment.

### **Service Delivery Area 3: Supportive environment (strengthening of civil society and institutional capacity building)**

**Indicator 10 – Number of NGO/CBO staff trained:** Various types of training programmes have been held for the staff of SR and SSR. These include, state level training in community preparedness for ARV, life skills education,

**Figure 15: No. of NGO/CBO staff trained**

advocacy, orientation programmes for new and old ORWs and Assistant Project Coordinators. Another feature of the second year was training of Community volunteers. A total of 1,270 programme staff have been trained in the second year, which is almost twice the number of staff trained in the first year (Figure 15). All the training programmes in Year 2 were held during Phase II of the programme because of increase in the number of ORW, recruitment of new staff and Community volunteers. No training programmes were held in the last two quarters of Phase 1 because the staff was already recruited and trained in the initial period of the programme.

### **Service Delivery Area 4: Information systems and operational research**

**Information system:** A web based software has been developed to track and monitor the services for each child. The software was first piloted at the beginning of Phase II at one of the SRs in Andhra Pradesh. Based on the feedback of this software, an updated version is being developed. It is expected that this software will help in feeding into the national Computerised Management Information System (CMIS) at state and national levels.

**Operational research:** A study on “facilitating HIV testing and disclosure with children and adolescents” explored testing and disclosure related issues in age specific categories of 0-6 years, 6-14 years and 14-18 years. The primary respondents for the study were the parents of children aged 0-14 and adolescent boys and girls in the age group of 15-18. Secondary respondents included community representatives like CLHIV network members, village school teachers, religious leaders, women’s group functionaries, village leaders, and service provider representatives from ICTC staff, field health functionaries, NGO representatives, etc.

**Documentation of good practices:** This documentation had the twin objectives of

**Table 5: Key findings of midterm evaluation**

Indicator	Baseline (%)	Midterm (%)
Children aged 14-17 years receiving vocational training	4.4	8.6
Children receiving educational support	14.8	64.6
Children receiving nutritional support	28.4	76
Adherence to ART	42	61
Access to health services:		
ICTC	62	91
ART centre	50	76
PHC	72	83
Private institutions	68	80
Access to welfare services and schemes:		
Anganwadi centres	66	85
Public distributions systems	69	91
Ration cards	NA	85
Employment guarantee scheme	8	39

capturing innovations and practices that have potential of becoming standard good practices in working with children affected and living with HIV and AIDS and have scope of replication. Key challenges faced in programme implementation and recommended solutions, approaches, and models from working in similar settings and global literature were also documented.

**Photo Documentation and Time series case study analysis:** This documentation and analysis has been initiated to track the development in the life of CLHIV and their families through the CHAHA programme for a year and to assess the change in their quality of life.

## Mid-term evaluation

The mid term evaluation of CHAHA was carried out at the beginning of Phase II which indicated that the percentage of children receiving vocational training, educational support, nutritional support and adherence had increased during the midterm evaluation as compared to the baseline. There was a significant increase in the access to various health services and welfare schemes and services of the government. The evaluation

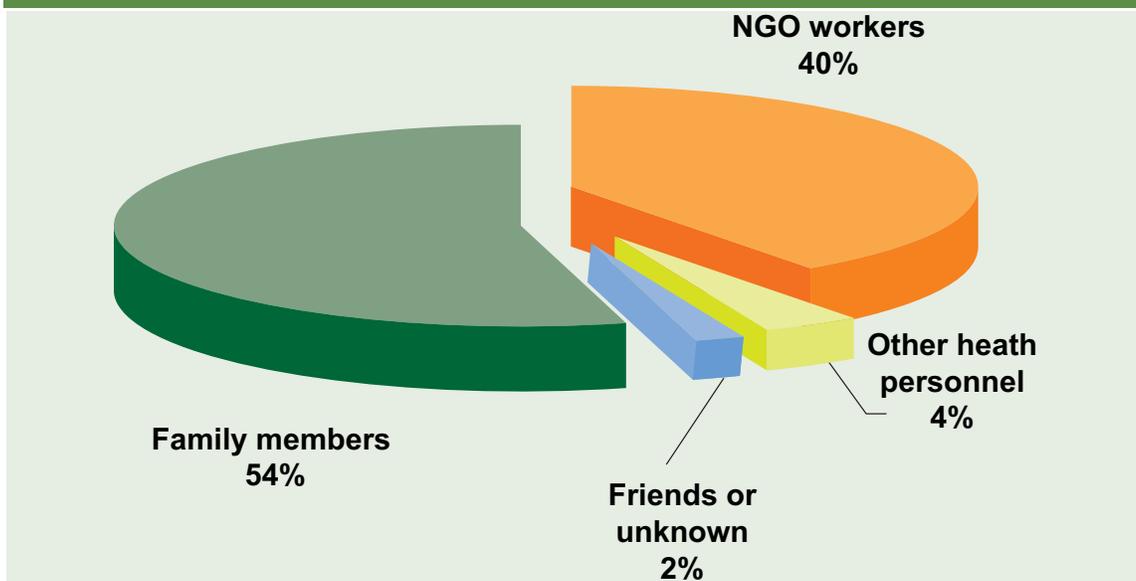
also indicated that discrimination against CLHIV/CAA continues to remain high among neighbours and schoolmates, and in fact was shown to be higher than the baseline (Table 5).

About 54% children were accompanied by the family member during their first visit to the ART centre. However, in about 40% of the cases, the children were accompanied by the NGO workers (Figure 16). This shows that the children and their families utilise the services of the ORW quite extensively.

When people on ART face difficulties in taking ART, the most frequently contacted person is the NGO worker (46%), which shows the extent of the rapport between the beneficiaries and the ORW (Figure 17).

## Conclusion

Year 2 of CHAHA programme was marked by significant changes. The project duration was reduced from 60 months to 43 months (19 months for Phase I and 24 months for Phase II) mainly because of the actual depreciation of the US\$ against the Indian Rupee during 2008 and the projections based on that. This

**Figure 16: Person accompanying for the first visit to ART centre**

necessitated readjustment of the targets for every quarter by increasing them significantly.

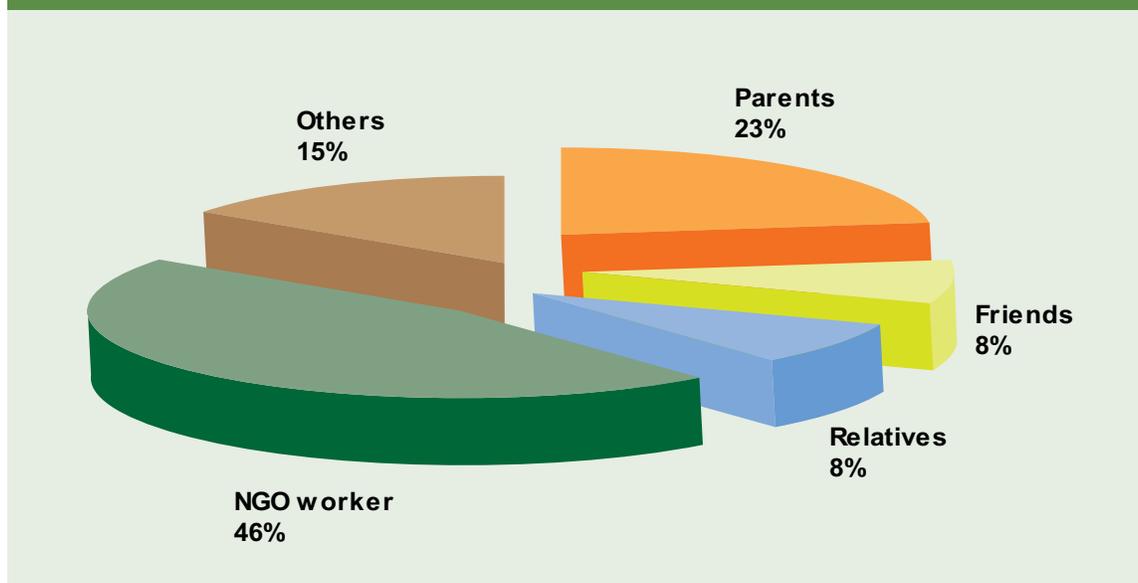
In Phase II of the programme, an additional post of Assistant Project Coordinator was created, the ratio of ORW to children was reduced from 1:60 from 1:75 and Community volunteers were recruited. The additional human resource has helped in achieving the modified higher targets and maintaining the quality of services and also setting the base for speeded up performance in the coming 19 months of the project .

One of the SR, Catholic Relief Services felt compelled to opt out of the programme but the work continues with the appointment of two additional SR for the states of Tamil Nadu and Maharashtra.

Closure of the Clinton Foundation project in 12 districts of the states of Maharashtra, Andhra Pradesh and Manipur necessitated absorption of about 2,500 CLHIV supported by this project into the CHAHA programme. This transition was carried out without adversely affecting the quality of services mainly because most of the NGO partners funded by the Clinton Foundation are also CHAHA partners.

The achievements in Year 2 have been almost double those of Year 1. The increase was observed more dramatically in the last quarter of the year as compared to the earlier three quarters. This was the time when the newly recruited programme staff and Community volunteers had been trained and had begun to provide services. This indicates that the programme is able to respond effectively to the challenge of achieving the same targets in a shorter duration. The achievements in eight of the ten indicators are more than 100%. It is lower for referral to ART centre mainly because most children enrolled are not in need of ART. This is an indirect indicator the success of the programme also, as the nutritional and psycho-social support and referral to various health services, has helped maintain higher levels of immunity among those living with HIV.

One of the impact indicators being tracked for the programme is the enrolment of orphan CLHIV/CAA aged 10-14 years into schools as compared to non CLHIV/CAA non orphan children in the same age group. The proportion had increased from 90.1% in baseline survey to 96.2% in midterm evaluation. Intensive community sensitisation and sensitisation of

**Figure 17: Person being contacted to overcome the difficulty due to ART**

various service providers and government officials have helped the children and their families benefit from the services.

At the time of proposal development, the HIV prevalence in India was estimated to be around 0.9% in 15-49 years age group. When the programme implementation began, the estimates were reduced to 0.36%. Despite the reduced estimate, which would normally mean enrolling the same number of children in roughly thrice the geographical area, the programme

has been able to achieve its targets for both the years.

Much more, however needs to be done. Midterm evaluation had indicated persistent stigma and discrimination, which had shown an increase from the baseline survey in some groups. Despite the direct and indirect evidence of reduced stigma and discrimination, midterm evaluation shows that much more needs to be done.

## Programme management

Alliance India recognises that any programme that involves working with the communities is best implemented by organisations that are based in the communities. Given the multiple social and cultural sensitivities, this is especially true for HIV programmes. Alliance India has been implementing the CHAHA programme through intermediary NGOs and provides them with programmatic, technical and financial support. It has also developed strategic alliances and partnerships with a range of stakeholders and institutions such as NACO, SACS, other government ministries and departments, health service providers, NGOs and research organisations.

Managing a large programme such as CHAHA requires setting up an effective management structure to ensure that the implementation is as per the proposed plans and strategies. These are briefly described here.

**Programme Coordination Unit:** This unit, based in New Delhi, has a team of

professionals who have facilitated effective programme delivery by ensuring that the quality is sustained, developing participatory and community friendly reporting systems and influencing the larger policy environment that is responsive to the specific needs of CLHIV and CAA. The four teams that comprise the Programme Coordination Unit are Care and support, Monitoring and evaluation, Knowledge management and Finance.

The programme Coordination Unit is actively involved in advocacy and policy formulation which will mitigate the adverse impacts of HIV and AIDS on children. In June 2008, it held a national consultation meeting with various stakeholders to disseminate the children and AIDS policy framework and operational guidelines protection, care and support of CLHIV/CAA. A major outcome of the workshop was to identify action points that would help take the discussion forward by identifying areas of collaboration. Pursuant to the national level workshop, Alliance India has held four state level consultations to disseminate the policy framework and the operational guidelines, and to design an advocacy strategy at state level to implement the operational guidelines. The aim of this policy is to:

- Create a non-stigmatizing environment
- Early identification of HIV infected parents and children and to provide high quality treatment and support
- Ensure that affected children are not excluded or treated differently by service providers in public and private sector
- Ensure that the social protection measures are in place.



The policy framework provides guidance to various ministries such as health, women and child development, human resource development and social justice and empowerment to develop and implement programmes for children and AIDS in a coordinated manner.

The state level consultations have been useful in advocacy and sensitising policy makers on the need for coordinated response, specialized counseling for children and their caregivers, special nutritional needs of CLHIV, need for educational support, inheritance issues and to reduce stigma and discrimination.

**Sub-Recipient (SR) and Sub Sub-Recipient (SSR):** These partners, located in the four implementing states, are selected after a rigorous selection process and are responsible for programme implementation. Alliance India selects the SRs while the SRs select the SSRs. The SRs are responsible for capacity enhancement of their SSRs for ensuring effective programme implementation at community level. They are also responsible for advocacy and reporting at state level. The SSRs work directly with the beneficiaries, build local capacities and establish effective networks and linkages at village, block and district levels.

**Coordination with the government and other stakeholders:** CHAHA programme design is based on the national operational guidelines to complement the National Policy Framework on Children and AIDS. There is a significant emphasis on establishing and sustaining strong referrals and linkages at community level in order to facilitate long-term sustainability of the programme. All the SRs and SSRs participate in state and district coordination meetings and link the community to various government schemes.

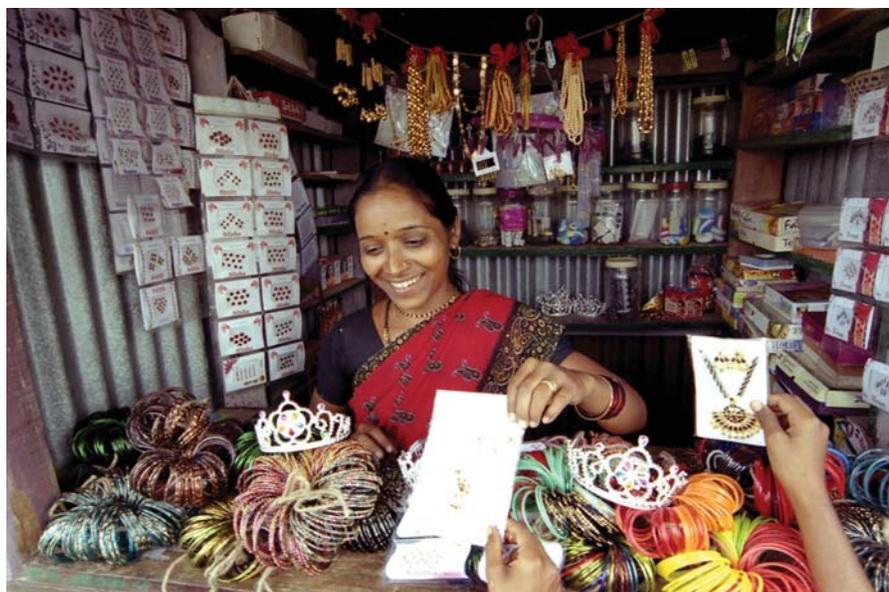
**Grants management:** The SRs have signed a grant agreement with the PR and the funds are disbursed through the SRs in the beginning of every quarter with a buffer of one month. The

SRs submit quarterly financial reports at the end of each quarter, which are audited every quarter by an external audit firm. Alliance India, which is responsible for the financial reporting to the Global Fund, collates the financial reports from all SRs.

**Monitoring and evaluation:** All the SRs and SSRs submit quarterly reports on key indicators, which are collated by Alliance India and submitted to the Global Fund. The SSRs have been trained in the standard operational guidelines and report the progress using a uniform reporting system developed by Alliance India. The progress report of the programme is incorporated by NACO in the CMIS. A midterm evaluation was done at the beginning of Phase II, which showed the progress of various indicators as compared to the baseline findings.

**Technical support visits:** Periodic and need-based technical support visits are made to the SRs and SSRs based on review and re-planning meetings, cross-cluster meetings and quarterly programme reports.

**Cross-cluster teams:** The programme Officers of Alliance India are divided into clusters based on their geographic location for a more efficient





coordination. Manipur and Maharashtra form one cluster whereas Tamil Nadu and Andhra Pradesh form another cluster. The cross-cluster teams meet twice a month and NGO and community levels. This system helps in quality assurance and pooling of skills for a more efficient programme management.

**On Track Management System:** This is an internal management tool used by Alliance India to facilitate a more systematic management discussion between programme and finance teams, to monitor progress against the plans, to

take corrective actions as and when necessary and to identify emerging risks.

**Mutual Sharing and Learning Meeting (MSLM):** This is a process for horizontal exchange of information. The meetings are held twice a year with all the SRs and SSRs in each state. The experiences of all partners are shared during this meeting, the success and impact of the strategies to achieve the targets are evaluated, duplication avoided and successful strategies are discussed for replication. During these meetings, the programme and finance teams also review the progress against the plans, and suggestive corrective measures, if any.



## Financial Summary

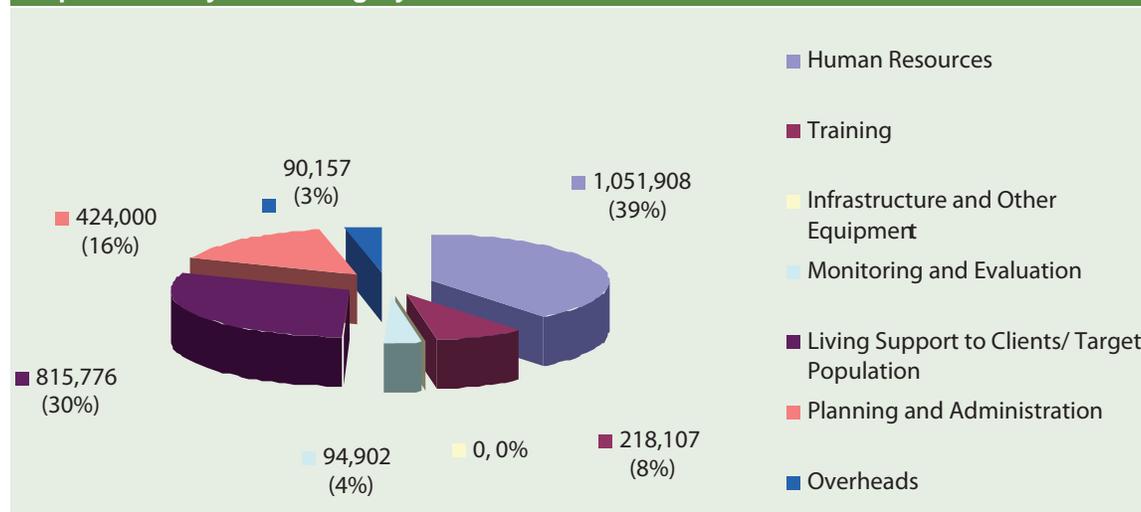
The Year 2 of the CHAHA Programme comprise of Phase 1 period of 7 months (July 08 to January 09) and 5 months of Phase 2. The period of Phase 1 was reduced by 4 months due to exchange rate fluctuations experiences during the year 1 of Phase 1.

The income received during Year 2 of the project is US\$2.77 million. The funding from Global Fund contributes to 30 per cent during the year.

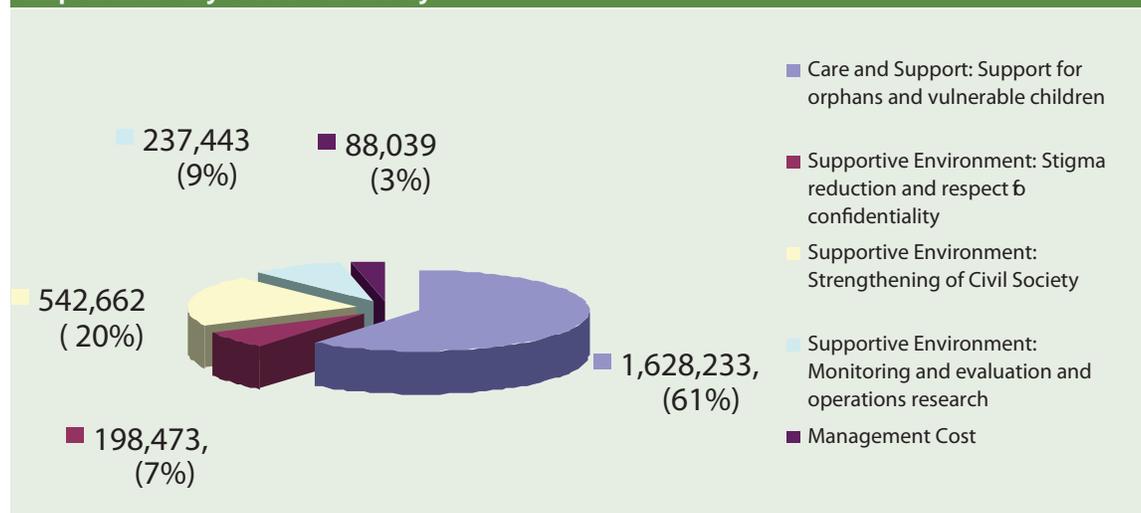
Expenditure at the end of Year 1 has crossed US\$2.69 million, of which onward grants to Sub-recipients constitute 75 per cent during the year.

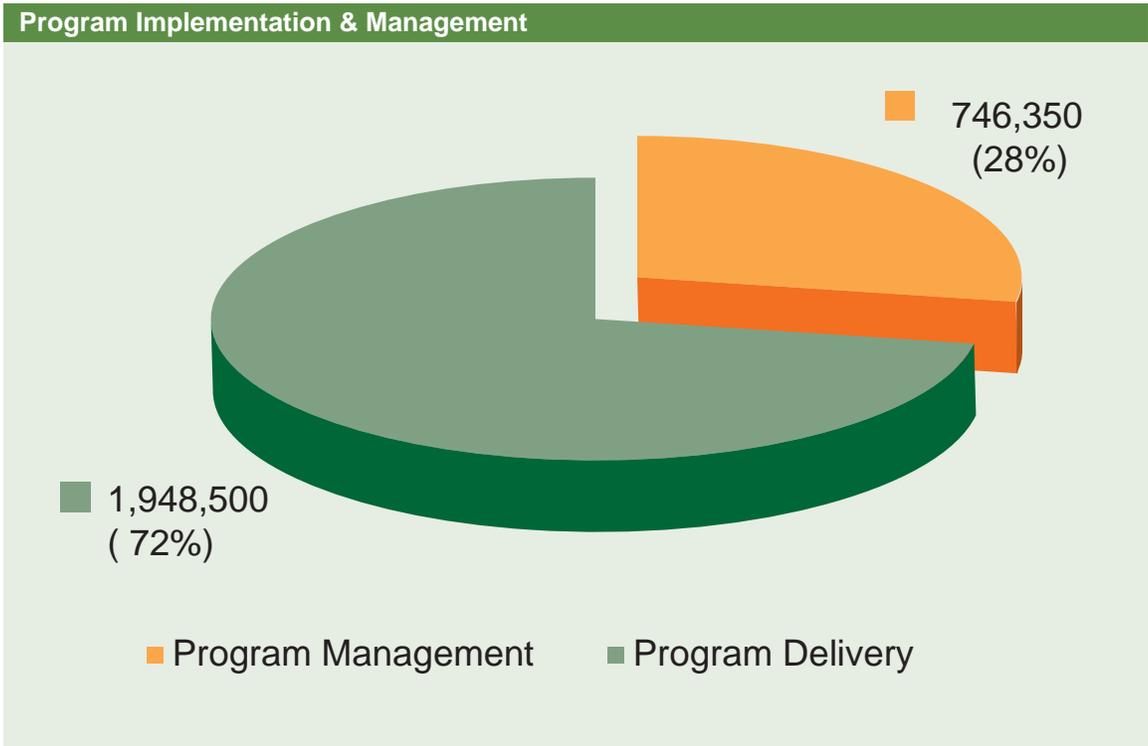
The funding has helped to strengthen the programme delivery and address the learning's from Year 1 of the grant. The quality of programme has been improved through better monitoring support through the partners.

### Expenditure By Cost Category



### Expenditure By Service Delivery





# Alliance India's CHAHA Partners

## Sub Recipients

**Alliance for AIDS Action, Andhra Pradesh**  
**Tamilnadu Social Service Society (TASOSS), Tamil Nadu**  
**LEPRA Society, Andhra Pradesh**  
**MAMTA-Health Institute for Mother and Child, Maharashtra**  
**Plan India, Andhra Pradesh & Maharashtra**  
**Palmyrah Workers Development Society (PWDS), Tamil Nadu**  
**Social Awareness Service Organisation (SASO), Manipur**  
**Vasavya Mahila Mandali (VMM), Andhra Pradesh**  
**Network of Maharashtra by People Living with HIV (NMP+), Maharashtra**  
**Catholic Relief Services (CRF), Tamil Nadu and Maharashtra\***

## Sub Sub Recipients

### Alliance for AIDS Action

Rural Education and Community Health (REACH)  
 Lodi Multipurpose Social Service Society (LMSSS)  
 Jagruthi

### Tamilnadu Social Service Society (TASOSS)

Centre for Education and Empowerment of the Marginalised (CEEMA)  
 Madurai Multipurpose Social Service Society (MMSSS)  
 Tiruchirappalli Multipurpose Social Service Society (TMSSS)  
 Thiruvannamalai Social Service Society (TVMSSS)

### LEPRA Society

GRAM Abhyudaya Mandali (GRAM)  
 Peoples Action for creative education (PEACE)  
 Hyderabad Leprosy Control and health society (HLCHS)  
 Divya Disha  
 Ravicherla Integrated Development and Educational society (RIDES)  
 Women's Organisation for Rural Development (WORD)

### MAMTA-HIMC

Bharatiya Adim Jati Sevak Sangh  
 RTM SAP Mandal  
 Janhitay Mandal  
 Kripa Foundation  
 Jeevan Vikas Sanstha  
 Nagpur Multipurpose Social Service Society

### Plan India, Andhra Pradesh

Arthik Samata Mandal  
 Janakalyan Welfare Society  
 Rural Energy for Environment Development Society (REEDS)  
 GUIDE  
 Society for Help Entire Lower & Rural People (HELP)  
 Social Activities for Rural Development Society  
 Chaitany Jyothi Welfare Society

### Plan India, Maharashtra

Committed Communities Development Trust  
 Community Aid & Sponsorship Programme (CASP)

### Palmyrah Workers Development Society (PWDS)

Anbalayam  
 Centre for Action and Rural Education (CARE)  
 Community Action for Social Transformation (CAST)  
 Centre for Social Reconstruction (CSR)  
 GRAMIUM  
 Native Medicare Charitable Trust (NMCT)  
 Peoples Association for Community Health Education Trust (PACHE Trust)  
 Scientific Educational Development for Community Organization (SEDCO)  
 Society for Rural Development and Protection of Environment (SRDPE)  
 Society for Serving Humanity (SSH)  
 Village Reconstruction and Development Project (VRDP)  
 Women's Organization in Rural Development (WORD)

### Social Awareness Service Organisation (SASO)

Manipur Network of Positive People (MNP+)  
 Dedicated People's Union (DPU)  
 Social Awareness Service Organisation (SASO) as an iNGO  
 Sneha Bhavan- Imphal East  
 Sneha Bhavan-Chandel  
 Sneha Bhavan – Thoubal

### Vasavya Mahila Mandali (VMM)

Deepthi Socio Educational Society  
 Gramasiri Rural Activities in National Development Society  
 Youth Club of Bejjipuram  
 Green Vision  
 ARDAR (Association for Rural Development and Action Research)  
 Rural Environment and Education Development Society (REEDS)

### Network of Maharashtra by people living with HIV/AIDS (NMP+)

Network of Maharashtra by people living with HIV/AIDS (NMP+) as an iNGO  
 Santhome Charitable Trust of Kalyan  
 Sangli Mission Society- Miraj  
 Sangli Mission Society- Kolhapur  
 Sarva Seva Sangh  
 Paramprasad Charitable Society, Satara  
 Paramprasad Charitable Society, Solapur

\* CRS in Maharashtra was replaced by NMP+ & in Tamil Nadu by TASOSS w.e.f. 1st April 2009



A global partnership:  
**International HIV/AIDS Alliance**  
Supporting community action on AIDS in developing countries



Alliance for AIDS Action  
[www.allianceforaidsaction.org](http://www.allianceforaidsaction.org)



Lepra India  
[www.lepraIndia.org](http://www.lepraIndia.org)



**MAMTA**  
Mamta - Health Institute  
for Mother & Child  
[www.mamta-himc.org](http://www.mamta-himc.org)



Palmyrah Workers  
Development Society  
[www.pwds.org](http://www.pwds.org)



Vasavya Mahila Mandali  
[www.vasavya.com](http://www.vasavya.com)



CATHOLIC RELIEF SERVICES



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Fax: +91-11-41633085  
Website: [www.aidsalliance.org](http://www.aidsalliance.org)  
Setu Virtual Resource Centre:  
[www.aidsallianceindia.net](http://www.aidsallianceindia.net)

Supporting Community Action on AIDS in India

# CHAHA PROGRAMME ANNUAL REPORT 2008 - 2009

