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Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV status.

Our Vision
A world in which people do not die of AIDS

Our Mission
To support community action to prevent HIV infection, to meet the challenges of AIDS and build healthier communities

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Step up, not back
Message from the Country Director

Dear friends,

In India as in other parts on the world, the response to HIV/AIDS is again at an inflection point. The significant attention that the epidemic has received over the past several years is beginning to dissipate. While India’s economy continues to grow at a remarkable pace, global economic weakness has led many donors to reconsider how to address HIV/AIDS more effectively with less funding.

The Indian national response has been distinguished by strong governmental leadership and a commitment, driven by data, to tackle the epidemic where it lives. India has not shied away from its responsibility to key populations, those disproportionately affected by the epidemic: sex workers, men who have sex with men (MSM), transgender people (TG), and injecting drug users (IDUs). The impact of this coordinated effort is reflected in evidence that suggests declining incidence and shows increased uptake of testing, treatment and other services.

India’s fourth National AIDS Control Programme (NACP-IV)—in development at the time of writing—will map out India’s HIV priorities for the next five years. Civil society has been actively engaged with the National AIDS Control Organisation (NACO) in this process, and Alliance India has been privileged to be part of these deliberations. With our strong relationship with government at national and state level, Alliance India, our Linking Organisations and other partners are uniquely well positioned to support NACO’s leadership.

While progress over the duration of NACP-III has been meaningful, it is clear that these efforts must be sustained to ensure that India can avoid entrenchment of the epidemic. Now is not the time to avert our gaze or shift our attention. Now is not the time to slow our efforts or reduce our investment. Now is the time to step up, not back.

It gives me great pleasure to present Alliance India’s annual report for 2010-11. In short, we’ve had a busy year. This year marked the end of CHAHA, a grant from the Global Fund that focused on children and families affected by the epidemic. This was truly a transformative programme for Alliance India and our implementing partners. It provided...
not only the chance to develop our institutional capacity to manage large programmes, but also more importantly served to build a compelling case for expanded care and support for PLHIV in India.

Our annual report describes the breadth of our growing portfolio: from Pehchān, our Global Fund-supported programme strengthening MSM, transgender and **hijra** organisations in 17 states to our Elton John AIDS Foundation-funded Chanura Kol programme working with female injecting drug users in Manipur; from our ongoing support of sex workers and MSM in Andhra Pradesh as part of the Bill & Melinda Gates Foundation’s Avahan India AIDS Initiative to our European Commission-funded work on sexual and reproductive health and rights (SRHR) advocacy with adolescents. The report also presents three essays by Alliance India staff members that bring to life some cornerstones of our work—community action, gender and SRHR-HIV integration.

None of what we do would be possible without our Linking Organisations and other implementing partners. These are the organisations that collaborate with communities and change lives. I remain in awe of Alliance India’s staff who bring their commitment and experience to bear on the epidemic each and every day. Their passion is inspiring. Our government partners—especially NACO and the State AIDS Control Societies—and our donors have been committed collaborators and steadfast supporters. My thanks to all of you who make our efforts matter.

Even as we manage a changing environment in India and the world beyond, this is undoubtedly a period of opportunity for impact that will build on the strengths that we have been nurturing and leveraging since our founding in 1999. Some lessons have been constant: Community action, human rights, and the prioritisation of key populations are not simply afterthoughts; they are essential to our success. Let us step up together.

James Robertson
The missing link
SRHR/HIV Integration for Key Populations

The International HIV/AIDS Alliance has long recognised the importance of integrating sexual and reproductive health and rights (SRHR) and HIV within policies and programmes. This is reflected in its current strategy ‘HIV and health communities’1, which commits the Alliance across its Linking Organisations and Country Offices to increase access and use of health services by (among others) strengthening linkages with sexual and reproductive health.

Alliance India is implementing this strategy in the context of its commitment to strengthening community level responses and structures and to focusing on and empowering key populations (men who have sex with men (MSM), transgender (TG), hijras, sex workers, people who use drugs and people living with HIV) who continue to be the most vulnerable to HIV in India.

HIV responses traditionally do not succeed to meet the SRHR related needs of key populations comprehensively. Programmes that support MSM for instance, often lack a comprehensive approach to sexuality or ignore the needs of married MSM and their female partners. Sex workers’ needs for contraception and maternal health services are often overlooked, as programmes focus on prevention and treatment of sexual transmitted

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infection (STI). There is a need therefore for a complete package of services to ensure that sexual and reproductive rights of key populations are realised. While integration of HIV into SRH services may increase access to HIV-related services for some communities, Alliance India challenges this notion for increasing access for key populations. However, expanding the services of focused interventions that are accessible and appropriate for key populations to meet their SRHR needs presents a critical entry point – to both increase access to SRHR-related services and to improve HIV-related outcomes.

To ensure that its commitments to key populations and community responses remain central to integrated programming across Alliance India, its Linking Organisations (LO) and other partners, Alliance India has been faced with some key strategic questions.

Do we have a strong evidence base to support SRHR/HIV integration as an effective approach to improve both SRHR and HIV outcomes for key populations? If so, what needs to be taken into account to ensure that SRHR/HIV integration does not compromise access to services for key populations?

While Alliance India has by no means been able to fully answer these questions, 2010 has provided some initial insight to shape integrated programming that can serve key populations’ SRHR- and HIV-related needs. Clearly, integration and linkages between HIV-related interventions and those to address broader SRHR concerns are clearly a desired goal in the long run. However, in the short run integration of services and systems that are not ready could compromise access and quality of services for key population if their rights and particular needs are not taken into account.

Understanding the SRHR needs of key populations

Comprehensive SRHR needs of key populations have been under-studied and therefore remain under-served. In order to ensure that any programming and policies reflect the needs of the communities, Alliance India has been collecting evidence through qualitative and quantitative methods among the communities it works with. The Chanura Kol project, supported by the Elton John AIDS Foundation and implemented by SASO in Manipur included a quantitative Knowledge Attitude Practice (KAP) study, which highlights the specific SRHR needs of women who inject drugs (see Box 1). A qualitative study to further elucidate some of these findings is currently being planned.

A qualitative study conducted among adolescents affected by and living with HIV highlighted the unmet need for SRHR-related information and services, including HIV prevention, among this community and supported the Alliance's call for a comprehensive response for children living with and affected by HIV – a response that not only addresses treatment, care and support needs, but also provides support for HIV prevention by ensuring that adolescents’ sexual and reproductive rights are realised (see Box 2). Currently, Alliance India Andhra Pradesh is undertaking a similar qualitative study among female sex workers to understand their specific SRHR-related needs.

A key population-focused approach to SRHR/HIV integration

Globally, the commitment to SRHR/HIV integrated and linked programming has increased over the last years with international commitments and funding approaches increasingly reflecting the need to address SRHR issues in HIV interventions and vice versa. The recently published review of evidence
While HIV transmission has been largely through injecting drug use in Manipur, sexual transmission is becoming an increasingly important factor. Furthermore, women who inject drugs (estimated to represent 7 percent of the drug using community, in the country) have been largely neglected in the current responses. Under the Chanura Kol project, a quantitative Knowledge, Attitudes and Practices Study was conducted among 150 women aged 18-49 years old who inject drugs in Manipur. Key findings suggest high rates of sexual and reproductive health concerns:

- 58 percent reported condom use every time during sexual intercourse over the previous month;
- 36 percent of women reported having regular menstrual cycles;
- unmet contraceptive need for limiting of pregnancies was found to be 56 percent among married women;
- 52 percent reported any STI-related symptom during the last 3 months, when prompted with a list of symptoms;
- 15 percent reported having experienced forced sex in the last 3 months.

The full report, *In the shadows: The Chanura Kol baseline study on women who inject drugs in Manipur, India*, can be downloaded from the Alliance India website.

Box 1: Key findings: SRHR needs among women who inject drugs

Study was conducted among 150 women aged 18-49 years old who inject drugs in Manipur.
Box 2: Key findings: The impact of HIV on SRHR needs of adolescents affected by and living with HIV

Within the context of CHAHA, a child-centred community-based care and support programme, a mini-study was conducted in Maharashtra, Manipur, Tamil Nadu and Andhra Pradesh using focus group discussions with boys and girls affected by and living with HIV between the ages of 10 and 18 (with a total of 160 respondents).

The study revealed that in addition to those vulnerabilities faced by adolescents in general – which include the impact of social norms relating to adolescent sexuality on individual behaviours, adequate information and service provision and access, and adoption and implementation of supportive laws - adolescents living with and affected by HIV were experiencing violence and abuse and face specific issues.

**Development:** Adolescents living with HIV raised concerns related to their delayed onset of puberty and physical development and their ability to raise a family when they are older.

**Right to a healthy sex life:** Adolescents described not wanting to engage in any relationships because they were afraid of ‘spoling other people’s lives with HIV’ and raised concerns about whether they would ever be able to get married and have children. They felt they had to control their desires because they are living with HIV.

**Access to information:** Issues relating to family support were particularly pertinent among adolescents who had lost one or both parents to HIV. The lack of family structures could limit the children’s access to even basic information related to health and hygiene and especially younger adolescents at risk given the amount of time they spent alone.

**Access to services:** In addition to the general lack of appropriate and accessible SRH services for adolescents, stigma and discrimination against PLHIV in health settings would further compound the difficulties in accessing services and requesting information, since discussion of their specific needs could require disclosing their status.

**Isolation:** Furthermore, HIV status of adolescents seemed to influence their level of engagement with peers and the community due to self-stigma and feared discrimination.

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The full research brief, *Sexual and reproductive health and rights - Key issues for adolescents affected by and living with HIV*, can be downloaded from Alliance India website.
on the benefits of bi-directional integration of SRH and HIV in programmes reported outcomes in terms of increase or improvement in access to and uptake of services, including HIV testing health and behavioural outcomes, condom use, HIV and STI knowledge and overall quality of service\(^2\). While these findings suggest that SRHR/HIV integrated programmes present a promising approach to improve services and outcomes, the review considered only few interventions from concentrated epidemic contexts and even fewer that focused on interventions for key populations.

Findings from consultations and studies\(^3\) among key populations also highlight significant concerns relating to the impact that a rapid scale-up of integrated services without dedicated efforts to take key populations into account can have on access and quality of services. Key population communities continue to face stigma & discrimination when accessing public SRH and general health services. These services are often unable to meet the specific needs of MSM, TG, PLHIV, sex workers and people who use drugs, due to lack of sensitivity to their needs and providers’ capacity to address these. Furthermore, few efforts succeed to take a rights-based, comprehensive approach addressing vulnerability linked to gender and sexuality, realising and respecting the sexual and reproductive rights of key populations. Where integration of services has relied on referrals between service providers, poor support and management of referral processes can compromise access to services. Even where obvious opportunities and structures already exist to provide integrated services and information, these are not used.

This includes for instance using post-test counselling as an opportunity to provide information, skills and services for positive prevention for PLHIV.\(^4\) These experiences with existing services highlight the need to take a carefully planned approach to scaling up the integration of SRH and HIV services as a mechanism to increase access for key populations. In the longer term, key populations’ access to HIV, SRH and health services through the public, mainstream health system should be an aim, showing that social inclusion of key populations has been overcome in this setting. However, before these challenges have to be addressed before it should be assumed that integration of SRH and HIV will maintain, or even increase, access to services and improve outcomes for key populations.

Community consultations have generated recommendations that need to be taken into account in planning, implementation and monitoring. Complementing existing studies,\(^5\) the CHAHA study (outlined in Box 2) provided some initial suggestions on the integration of SRHR interventions


\(^3\) Compiled from:
- PATH (2007). Options and Challenges for Converging HIV and SRH Services in India: Findings from an Assessment in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh. New Delhi, PATH.
- India HIV/AIDS Alliance and SASO (2011). In the Shadows: The Chanura Kol baseline study on women who inject drugs in Manipur, India. New Delhi, India HIV/AIDS Alliance.
- Chakrapani et al (2008). SRH of PLHIV in India. (mixed methods study). Indian Network of People living with HIV.

\(^4\) For example: PATH (2007). Options and Challenges for Converging HIV and SRH Services in India: Findings from an Assessment in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh. New Delhi, PATH.
within existing structures for care and support. Similar studies are underway among female sex workers in Andhra Pradesh, among women who inject drugs in Manipur and MSM and TG in Maharashtra and Andhra Pradesh, and will provide similar recommendations from the communities themselves. Alliance India’s new project, supported by the European Commission (EC), working with People Living with HIV (PLHIV) networks in four states across India will support mechanisms of collection of evidence and feedback from district-level Community Based Organisations (CBOs). This will directly inform advocacy and recommendations for programme implementation (see Box 3) for integrated programming and policies to meet the SRHR needs of PLHIV.

Supporting community engagement in policy and advocacy for SRHR

Alliance India supports a comprehensive approach to integration and considers the enabling policy and legal environment as a key factor in decreasing key populations’ vulnerability to HIV, poor SRH and rights violations. Realisation of sexual and reproductive rights is not only a critical component of achieving HIV and SRH-related health outcomes, but also an end worthy in and of itself.

Key populations continue to face violations of their sexual and reproductive rights. Young women living with HIV are subjected to forced sterilisation, MSM continue to face harassment by law enforcement and service providers on the basis of their sexuality, sex workers face sexual violence. While the majority of cases remain unreported and unaddressed, support for communities to advocate and respond to violations is a critical component to ensure the realisation of their rights and to creating an enabling political and legal environment.

India has recently made important progress in realising the sexual rights of men who have sex with men with the Delhi High Court’s judgment on Section 377. In partnership with the International HIV/AIDS Alliance, Alliance India is documenting the role that civil society actors played in this process. Furthermore, the Alliance’s Linking Organisation Humsafar Trust has been
conducting community reviews to assess the impact that the success in law reform has had on the community (see Box 4).

As political support for integrated programming and approaches increases in India, upcoming processes linked to the development of future HIV-related policies and implementation plans in India, such as NACP-IV and its SRH-related counterpart Reproductive and Child Health (RCH-3), are critical opportunities to shape the face of future interventions in India. While proposals to integrate the HIV response within the National Rural Health Missions are being considered, Alliance India is supporting key population communities to engage in relevant policy processes at local, state and national levels.

While community networks and organisations of key population have engaged successfully on HIV-related issues, particularly treatment access, their engagement on SRHR-related issues has been limited. Since February 2010, Alliance India and its partners SASO and MAMTA in India and the Alliance’s Linking Organisation HASAB in Bangladesh have been supporting civil society organisations and young people themselves to engage in advocacy on young people’s SRHR. The Action Project places a particular focus on involving young people from key population communities (see Box 5). Through its new ‘EC PLHIV’ project, supported by the European Commission, Alliance partner CHETNA and Linking Organisations – VMM, MAMTA and PWDS working in Gujarat, Andhra Pradesh, Maharashtra and Tamil Nadu respectively, are partnering with the respective state-level networks of PLHIV to improve the realisation of SRHR of PLHIV in these four states (see below, Box 4).

These two projects not only directly increase access to SRHR-related information and services for the respective communities, but also increase capacity and resources to enable meaningful engagement in advocacy. Through its Chanura Kol project in Manipur, SASO is adapting its existing approach of Core Advocacy Groups to the needs of women who inject drugs, supporting community-led responses to cases of violence and harassment (Box 6).

**Box 4: Realising sexual rights: Sharing India’s story across the Commonwealth**

With support from the Commonwealth Foundation, the International HIV/AIDS Alliance has been engaging in efforts to support law reform for rights-based HIV approaches across the Commonwealth. To support this process, Alliance India has worked with key stakeholders to develop a documentary film of the process that led to the Delhi High Court judgment in 2009 that ruled Section 377 of the IPC as it pertains to consensual same-sex sexual behaviour between adults is unconstitutional. Various civil society actors, public figures and members of the community played a critical role in shaping the enabling environment that allowed for the judgment. Alliance India’s documentary aims to highlight the contributions made by these various actors to inspire and inform similar movements in other countries in the Commonwealth. In addition, the Alliance’s Linking Organisation Humsafar Trust, in its role as Secretariat of INFOSEM, has been assessing the impact of the judgment on the community. A survey among community members, complemented by a consultation with stakeholders, highlights the impact on individual lives and the challenges that, following successful law reform, remain to ensure that sexual rights are realised.

While community networks and organisations have engaged successfully on HIV-related issues, particularly treatment access, their engagement on SRHR-related issues has been limited.
The Action Project, supported by the EC, has been engaged in advocacy for the realisation of young people’s SRHR in two states in India, Manipur and UP, and in Bangladesh. Across the three sites, CSOs have been supported to engage in advocacy at the district- and state-level. Young people have formed a total of 104 peer-led youth groups meeting regularly and are receiving SRH-related information and life skills. Peer leaders also take the lead in local and district-level advocacy. While state-level advocacy is the focus for the upcoming year, some initial successes have been made. In Manipur, SASO’s engagement with the National Rural Health Mission (NRHM) has resulted in the draft state-level programme implementation plan for the upcoming year including a new focus on youth-friendly services, a help-line for young people, and SRHR-related IEC materials for young people. In UP, MAMTA is currently engaging in efforts to ensure that peer leaders are formally included in village and district-level health and sanitation committees in Etawah and Allahabad. Project partners have also secured a place on the district health society of Allahabad to ensure input on young people’s SRHR.

**Box 5: Increasing young people’s involvement in policy and decision-making processes**
Box 6: Using core advocacy groups to address violence against women who inject drugs in Manipur

As part of the efforts to address stigma and discrimination and cases of violence against women who inject drugs, SASO, with support provided under the ‘Chanura Kol’ project has established four Core Advocacy Groups (CAGs) each consisting mainly of women who inject drugs. CAG members have received training on advocacy and on documentation. Since their establishment in early 2011, 20 cases of violence, harassment and extortion were reported to the CAGs. Incidents mainly included three kinds of incidents such as domestic violence and harassment by sexual partners, harassment by pressure groups and harassment by security forces, who extort money particularly from those women engaged in sex work. The vast majority of the cases were responded to by the respective CAG in less than 48 hours and support provided to those affected and their families. In addition, sensitisation and advocacy meetings were held with those involved in perpetrating the violence.

As there is increasing attention and focus given to integration of HIV with other health issues, including sexual and reproductive health, Alliance India continues to place the needs and rights of key populations at the centre of new approaches. While Alliance India fully supports the realisation of sexual and reproductive rights of key populations and the need to meet their SRH-related needs, questions remain on appropriate programming approaches and how integration can be used as an effective approach for key populations. Integration and linkages between HIV related interventions and those to address broader SRHR concerns are clearly a desired goal in the long run. However, in the short run integration of services and systems that are not ready could compromise access and quality of services for key populations if their rights and particulars needs are not taken into account. Through its efforts to strengthen the evidence base on the SRHR needs of key populations and the establishment community-level approaches, Alliance India and its LOs and partners have increased their understanding of integrated programming for key populations. With efforts to improve the evidence base, lessons from ongoing programming and recommendations from the communities we work with, Alliance India continues to strengthen its programming in this area.

Sunita Grote
Programme Manager, SRHR
The Action Project
(2010-2013)

Funded by the European Commission, the Action Project supports community mobilisation and advocacy. Its overall objective is to improve the sexual and reproductive health (SRH) and rights of young people in South Asia. It aims to focus particularly on the most marginalised young people – MSM, transgenders, drug users, sex workers and those living with HIV. The project is being implemented in partnership with MAMTA and Social Awareness Service Organization (SASO) in India and by HIV/AIDS and STD Alliance Bangladesh (HASAB), in Bangladesh. The project endeavours to strengthen and empower civil society organisations and youth groups to advocate for more responsive policies addressing the SRH and rights of young people.

BANGLADESH
Bangladesh Lead Partner: HASAB

Implementing Partners
Centre for Asian Theatre
Khulna Muktibhanga Seba Sangstha (KMSS)
Reliant Women Development Organization (RWDO)
Association for Community Development (ACD)

The Action Project endeavours to strengthen and empower civil society organisations and youth groups to advocate for more responsive policies addressing the SRH and rights of young people.
By 2013, the Action project will have contributed to shaping SRH and rights policies and their implementation in India and Bangladesh by supporting the meaningful participation of young people in relevant processes and programmes.

A total of 2,134 youth aged 15-24 have been reached by the project during the period. A total of 192 youth groups have been formed which have been functioning regularly. The project has made some notable advocacy-related achievements. In Manipur, the Project Implementation Plan (PIP) 2011 of the National Rural Health Mission (NRHM) for the first time includes provisions and budget for the establishment of pilot sites for youth-friendly health services in Imphal East and West. A commitment has also been made to establish a hotline for young people and to disseminate youth-friendly IEC materials on SRHR.

In Uttar Pradesh, the NRHM has sought a wider role for peer leaders and youth groups under the project through their involvement in the village and block level health and sanitation committees as well in the development of a gender and rights sensitive SRH development plan. The support of youth groups has also been sought in mobilising people on district-level efforts on prevention of STI and HIV.

**INDIA**

**Uttar Pradesh Lead Partner:** MAMTA

- Rashtriya Ashaya Sewashram Parishad
- Manjul Mahila Kalyan Samiti
- Dalit Vikas Sansthan

**Manipur Lead Partner:** SASO

- Awaken Artisan Shelter Association (AASHA)
- Future Development Drug User Organization (FDDUO)
In 2010, Alliance India, together with SASO, received a grant from the Elton John AIDS Foundation (EJAF) to expand interventions to reduce drug relapse among female injecting drug users (FIDUs). Using an approach that is both holistic and sustainable, Chanura Kol aims to address the root causes of vulnerability and the primary causes of relapse post-detoxification.

Incorporating input from FIDUs in Manipur, it provides these women with longer term shelter, creates opportunities for income generation.
outside of sex work, and encourages the rebuilding of family relationships. At the end of three years, the programme will reach 700 FIDUs and demonstrate the critical role that post-detoxification support plays in successful interventions. Chanura Kol builds on the success of a similar care and support programme with FIDUs in Manipur.

Of the estimated target population of 700 females who inject drugs in the intervention districts – Imphal (SASO), Churachandpur (SHALOM) and Chandel (DPU) – 357 were enrolled in the project. During the period, the total number of needles and syringes provided was 60,354 and 1,00,964 condoms were provided during the same period. Drop-in-centre (DIC) services were utilised by a total of 431 IDUs. Night shelter services were accessed by 85 FIDUs. A key element of the project is the provision of income generation support to prevent post-detoxification relapse due to lack of gainful economic opportunities. During the period, 22 FIDUs have been linked to vocational training opportunities and 9 have been provided with income generation support.

In 2010, Alliance India, together with SASO, received a grant from the Elton John AIDS Foundation to expand interventions to reduce drug relapse among female injecting drug users.
Beyond a Binary

Gender in the work of Alliance India

Abhina Aher is the Programme Manager for Pehchaan, the largest single-country Global Fund grant supporting programming for MSM, transgender and hijra communities. For Abhina, the journey of owning and embracing her gender has been long and arduous. It started with a childhood restricted by parental expectations, social conditioning through rejection, homophobia and rewards linked to “normalisation.” Abhina (who was then Abhijit) dated girls and tried hard to conform to the expected norms of masculinity, which defined his attire, his body language, and even his relationships. He could not escape his essential desire to be treated and touched as a woman. His love of dancing allowed him to cross-dress and embrace his inherent “femininity.” Abhijit was surprised at how little support he got even from the larger gay community as he began expressing his true gender more widely and honestly. Abhina had started the journey to find herself. She has integrated her life experience into her career, working on projects with transgender groups in Mumbai and now with Alliance India, and has now begun the process of gender transformation including surgical reassignment from male to female.

But many MSM and transgendered people do not have the courage to get as far as Abhina has. Most MSM in this country end up getting married unable to avoid societal and familial norms. Men and women alike pay a huge price in this country to conform to an often rigid and inflexible notion of gender amidst other social and moral norms. A culture that denies individuals the space to be who they are risks undermining itself. Marriage should be a matter of individual choice, not a compulsory social institution; for so many MSM and transgenders in India, marriage was inescapable. The options that are available to people have a profound impact on how individuals (both male and female) experience and negotiate their sexual lives and their vulnerabilities.

Gender illuminates, sometimes in the most unexpected ways, the complexity, delicacy and constant contradictions of human interactions. Gender is something that adheres to us, regardless of anatomical sex. The ‘trouble’ arises when we see biological sex as the cause of innate gender traits rather than a construct informed by conditioning, culture, family, age, self-esteem and the space you occupy (to name a few). Gender is not just about women and girls. This essay attempts to configure the surface of the vast landscape of gender which involves men and boys as much as women and girls; connects the dots between gender identities and sexuality; explores its relationship to HIV vulnerabilities; and what interventions can do (and undo) to address an individual’s experience and public expression of gender.
Genders are living entities, and as they evolve and grow, it is impossible to predict which elements of one or the other will prevail. Equally, gender is not rigid as many would like to believe or exhibit that it can be bent; we are in that sense blends of the masculine and feminine. Our sense of identity is never simple or permanent. It involves a hybrid of identities: nationality, marital status, caste, class, sexual orientation, and so on, that sum up to “who we are.” Importantly, it includes our gender identities.

These questions are not academic. There is a modernised form of social apartheid in India, superimposed upon older systems of caste; and the way in which gender and sexual identity is constructed reflects this growing divide. The absence of self-identification among the majority of those oriented towards same-sex desire in India has indisputably driven the transmission of HIV and other sexually transmitted infections. Alliance India’s Pehchān programme (Global Fund Round 9) works with MSM, transgender and hijra (MTH) communities, who, by their very existence subvert the prescription and proscription of gender norms. Recognising the many categories and definitions at work in MTH communities in India, Pehchān embraces a paradigm of sexual and gender identity that is as inclusive as possible. The programme will address issues such as the pressure to marry...
experienced by many MSM and will develop innovative pilots to address the needs of spouses and other female partners of community members.

The politics and problems of gender also extend to other marginalised groups that Alliance India works with, in particular, women who inject drugs through Chanura Kol, a project funded by the Elton John AIDS Foundation. This population has specific needs that remain unaddressed in current programming, and encroachment on their rights due to entrenched gender norms place these women in situations of powerlessness and vulnerability, decreasing their ability to access services. Using a holistic approach, Chanura Kol is aiming to tackle these challenges.

Gender blindness in HIV programming for people who inject drugs has meant that women's drug use often remains hidden. Women users seldom come forward to take part in interventions or participate in research. Their needs remain under-represented in harm reduction literature. This situation creates the illusion that they do not exist in sufficient numbers to create programmes for them in the first place. Women who inject drugs face multiple sources of vulnerability to HIV, including through injecting drug use, sexual transmission and gender-based violence (often exacerbated through their involvement in sex work). Gender dynamics not only limit their negotiation power for safer sex, access to services but also determine injecting and drug use practices. The social standing for these women is further undermined by drug use and HIV-related stigma and discrimination, which is often more severe than against men who inject drugs.

Chanura Kol aims to support women who inject drugs in Manipur by addressing multiple sources of vulnerability through drug use, sex work and social exclusion. The project provides harm reduction, HIV prevention, general health and social services while providing opportunities to drug treatment, social reintegration and income generation.

The dynamics of gender also severely impact the lives of those affected by HIV. In a recent Alliance India study\(^1\) on sexual and reproductive health and rights for adolescents affected by and living with HIV under CHAHA (Global Fund Round 6), discussions with parents show that social norms and expectations guide how they treat their children from an early age. Parents restrict contact between girls and boys, denying both the opportunity to interact. Adolescent girls found it difficult to discuss being involved with boys their own age and also spoke about feeling unsafe in public, for fear of being teased, harassed and even touched inappropriately by boys and men. Even crowded places and public transport were described as risky. Adolescents report sexual violence in their lives and those of their peers, highlighting an urgent need for strong measures for child protection, age appropriate sexuality education and empowerment.

Alliance India’s work with CHAHA also showed how HIV-affected and infected widows are subjected to community and familial norms which further marginalise them. The position of widows in a significant section

\(^1\) India HIV/AIDS Alliance (2011). Research Brief: Sexual and reproductive health and rights - Key issues for adolescents affected by and living with HIV. New Delhi, India HIV/AIDS Alliance.
of Indian society is strongly influenced by practices that govern gender relations as a whole. A system of patrilocal residence exists in many parts of India, which after marriage puts women in a position of vulnerability. Similarly, the system of patrilineal inheritance and the division of labour by gender place limit a women’s ability to engage in income generating activities and her economic dependence and subsequently restrict autonomy and decision making. Once widowed, a woman’s options are severely limited, and HIV adds a further layer of stigma. The marginalisation of widows in Northern India in particular, is consistent with the traditional perception of Hindu widows as inauspicious and guilty women who should lead lives of austerity devoted to the memory of their husbands. As crucial is the simple fact that widows are often seen as an economic burden.

Programmes like Pehchān, Chanura Kol and CHAHA address gender norms to increase the impact of HIV interventions with vulnerable populations. But people are too complex to be reduced to fixed images and stereotypes. Labelling tends to simplify people and cut them off from one another. It’s easier to avoid dealing with individual differences. For all people – people of any and all sexual orientations, men and boys, women and girls, and the transgendered as well – challenging these assumptions requires sensitivity, courage and humility. Those who reject popular imagery and overcome gender apartheid can celebrate a small victory in a profoundly human battle; they are lodestars amidst the darkness of fear, stigma and taboo.

The truth, meanwhile, is richer, more complex, more satisfying, and, to be sure, more problematic. Avoiding the problem in ill-conceived interventions only serves to validate and perpetuate it. As the Alliance, we need to question forces that create gender images and pigeonhole people into tight and limiting boxes. We should ask ourselves if we are doing enough to challenge the gender power-plays that protect vested interests in a largely patriarchal and heterosexist world.

Gender is always open, in flux and often performative. After all, a cocksure swagger has always been as much an act as a limp wrist. But few are capable of acknowledging this rather simple and obvious fact. For if they did, it might just fragment that sense of who they are and even shatter their identities.

Shaleen Rakesh
Director, Technical Support

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Programmes like Pehchān, Chanura Kol and CHAHA address gender norms to increase the impact of HIV interventions with vulnerable populations.
Avahan India AIDS Initiative is a focused HIV prevention initiative funded by the Bill & Melinda Gates Foundation. Alliance India is one of two Avahan state lead partners working in Andhra Pradesh. Now in Phase II, Alliance India is implementing the programme in seven districts and has begun the process of transitioning activities to the state government. The goal of Avahan is to reduce HIV transmission and prevalence of STIs in vulnerable high-risk populations (FSW, MSM and transgenders) through education and services. The programme also supports the creation of an enabling environment to increase the effectiveness of the HIV response through individual and organisational capacity building.

Alliance India’s efforts with Avahan strengthen the capacity of NGOs and CBOs in the state to implement

**Andhra Pradesh**

**Lead Partner:**

District Anantapur
- Centre for Rural Action (CERA)
- Chaitanya Rural Education and Development Society (CHAITANYA)
- Forum for Rural Development (FORD)
- Human and Natural Resources Development Society (HANDS)
- Jana Jagruthi
- Rural Education and Development Society (KREDS)
- Mass Education & Organisation Society (MEOS)
- Rural Integrated Development Society (RIDS)

District Chittoor
- Collective Order for Rural Reconstruction Education (CORE)
- Chittoor Rural Leprosy Rehabilitation and Social Welfare Association (CRLR&SWA)*
- Janachetana
- Krushi Samstha
- People’s Action for Social Service (PASS)
- Rural Reconstruction Society (RRS)
- Serve, Train, Educate People Society (STEPS)

District Khammam
- Jagruthi
- Socio-Economic & Cultural Upliftment in Rural Environment (SECURE)
- Society for Integrated and Rural Improvement

District Karimnagar
- Gram Nava Nirmana Samithi (GNNS)
- Rural Education and Community Health (REACH)

District Nalgonda
- Association for Needy and Kindle the Illiterate through Action (ANKITA)
- Green Cross Society (GCS)**
- Society for Community Education & Economic Development (SCEED)**

*Transitioned from APSACS: July 1, 2011

**Scaled up: November 1, 2011"
quality HIV prevention programmes in close partnership with the Andhra Pradesh State AIDS Control Society (APSACS) and in accordance with its mandate under the national programme. Apart from the infrastructure of the project, Alliance has managed to build a strong base of 40 NGOs that have been strengthened in programme management skills.

Alliance is presently covering 47,201 FSW, MSM and TGs in 123 sites of seven districts of Andhra Pradesh. In 2010 the programme coverage was scaled up in 18 sites/mandals i.e., around 5,049 HRGs. At the same time 13,504 HRGs in 5 districts were transitioned to APSACS in the district distribution in July 2010.

There has been significant progress in the health seeking behaviour amongst the HRGs. In 2010, about 83 percent of the population (81 percent FSW and 85 percent MSM/TGs) were outreached regularly and were provided with condoms (32,583,593 free and 3,46,095 socially marketed). About 77 percent of KPs (75 percent FSW and 81 percent MSM/TGs) attended 25 static and 97 public private partnership STI clinics every quarter for STI screening (of those who attended, 96 percent were tested for syphilis) and 36,212 KPs were referred to ICTC testing centres. The 97 drop-in-centres provide a safe space for the community where they also conduct their group meetings and discuss their common issues.
In 2007, CHAHA was initiated to mitigate the adverse impact of HIV on children. It aims to provide a holistic response to the needs of children and families affected by HIV.

As a Principal Recipient under Global Fund Round 6, Alliance India leads CHAHA with eight consortium partners (LEPRA, MAMTA, PWDS, SASO, VMM, NMP+, Plan India, and TASOSS) in 41 districts in the states of Maharashtra, Andhra Pradesh, Tamil Nadu and Manipur. The CHAHA programme has reached 64,000 children making it the single largest comprehensive care & support programme for children affected by AIDS in India.
In many places, the number of children and families in need of support has far exceeded the numbers anticipated when the programme was designed, pointing to the need for an expanded care & support response for children and their families, often headed by widows. Many stakeholders, including those in government, now acknowledge there is a lack of support for children within NACP-III. Seven SACS, including all four CHAHA states, have supported the expansion of the programme.

During the last year, 21,540 new children were provided with home based care and support service in four states of the programme coverage area. A total of 64,056 children have been reached with the minimum package of services of which 8,563 children have received supplementary nutritional support. 4,028 received educational support, 653 children were put on ART, 2,089 households have been provided with income generation support and 10,859 households living with CAA/CLHIV have been supported with basic support services. During the period, 273 new support groups were formed. A total of 538 sensitisation meetings were conducted with a total of 8,837 participating in the sensitisation meetings.

**MANIPUR**

**Social Awareness Service Organisation (SASO)**

Social Awareness Service Organisation
Manipur Network of Positive People (MNP+)
Dedicated People’s Union (DPU)
Sneha Bhavan

**TAMIL NADU**

**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 Organisation in Rural Development (WORD)

**Tamil Nadu 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)
Men who have sex with men (MSM), *hijras* and transgender communities across India are doing something considered by many to be audacious: they are demanding legitimacy from their local governments. To support their efforts to protect the health and wellbeing of their communities, they are registering as organisations under the Societies Registration Act 1860, a law that was created by the British around the same time as India’s antisodomy statute Indian Penal Code (IPC) Section 377. Although the anti-sodomy section was read down by the Delhi High Court in July 2009, MSM, transgenders and *hijras* continue to face regular discrimination and violence. Despite this and in some cases as a result of it, many MSM and transgender groups are exercising their right to organise. Groups that used to meet informally in public parks and bus stands now have bylaws, elected office bearers, accounting systems, and the other necessary organisational machinery to support their work. As one community member commented, “I used to feel threatened by local rowdies in my area. Now I walk in the streets of my town with confidence knowing I have my organisation to back me.”
Why does this matter? First, marginalised groups have been afforded legitimacy by a system that typically treated them with abhorrence and disrespect, and in some cases even denied their existence. Second, it enables groups to work officially: protests, World AIDS Day events, support group meetings, condom distribution and other critical HIV prevention activities become a possibility only when groups have a recognised legal status. Third, it is a first step towards becoming eligible for funding from government and other donors, which is essential if these organisations and their work is to be sustained. Last and certainly not least, registration can be an act of tremendous personal courage, as it requires registers to write their names and addresses on their application; for many, this is their first instance of associating themselves formally with their sexuality or gender identity. Over time, we have even seen instances of government registrars and other officials who are part of the process develop friendships with community members. Registration is an ultimate expression of “we’re here, get used to it,” and it is remarkably good news that so many communities across the country are doing it.

Through the Global Fund-supported Pehchaṇ programme, Alliance India and six implementing partners are developing the capacity of 200 community-based organisations in 17 states to provide services to promote the health and wellbeing of their communities. Pehchaṇ is focused on community systems strengthening. Increased community participation in the HIV response has been accompanied by a marked increase the reach and uptake of services, both within and outside MSM, transgender and hijra communities. There are many examples of community-driven work that has achieved the relevance and reach that other approaches cannot: after all, who knows community needs better than community themselves? We have seen groups performing street theatre in village squares filled with people of all ages sitting on empty oil cans, tree logs, and dusty rocks watching stories of men loving men. Crisis and violence response teams have organised briskly in the face of harassment and other defamation, assisting and protecting community member rights and helping them to avoid future threats.

Communities are assisting State AIDS Control Societies to train police and health officials on their specific needs and concerns. It is not uncommon during police trainings for sari-clad hijras and MSM to lead sessions on why and how police services can be made more friendly and inclusive for the community. Media advocacy has yielded results, and instances of stories that accurately and respectfully portray sexuality and gender identity differences are penetrating into the homes and minds of the media-consuming public. The richness and value of the results are evident on multiple levels: with the project implementers themselves; in the populations they target; and in society at large. The process of working on an HIV prevention project itself can increase community pride and self-esteem, helping them to see latent strengths and capacity they might have thought they didn’t have. And a community that loves itself, protects itself.

Despite the success of such efforts, there still remains a lack of confidence in community ability to manage and run programming. While many implementers will claim “community involvement,” the reality is less engaged and sometimes little more than a tokenistic nod to communities as part of
Lack of accountability to beneficiary communities in HIV programme governance discourages the addressing of real community needs and leaves no check to ensure ethical programme implementation. Pehchān is committed to maintaining accountability to its beneficiary communities and has an in-built governance structure that does this. Community Advisory Boards (CABs) are a governance structure comprised exclusively of community members who participate in programme decision-making processes, provide technical inputs, and assist in conflict mediation at all levels of programme implementation. They also have the authority to raise issues and concerns, serving as a watchdog body to ensure the programme’s ethical implementation. The Pehchān programme has formed six CABs, representing 17 states. CAB membership, which rotates on a yearly basis, is comprised of Pehchān’s beneficiary groups: MSM, transgender, and hijras; at least one of whom should be PLHIV; and its members should have a minimum of 3-5 years’ experience in HIV programmes. Key CAB responsibilities include:

- Providing technical inputs to inform programme functioning and policies
- Supporting relationship strengthening with State AIDS Control Societies
- Guiding and ensure action on priority issues of the community
- Advising best means to synergise with existing programmes and projects
- Assisting in conflict mediation, as needed
The concept of community may differentiate one group from another, while simultaneously recognising the integral connection between them.

otherwise top-down approaches. It is all too easy to make assumptions of what constitutes “support” for communities and what interventions make the most sense to achieve improved HIV outcomes. We may want to rely on logic, or what is most measurable, or most achievable within a given set of circumstances. Programming for communities can be compromised, irrespective of how wise or viable it may seem, unless it is informed by the communities who may benefit. Addressing this from the start, from programme conception through planning and implementation ensures interventions outlive funding streams. This is crucial to building effective and sustainable interventions with communities, and programmes should be structured to support this process. Pehchañ’s Community Advisory Boards (CABs) are one example of how this can be accomplished. (See Box 7.) As one CAB member commented, “A Community Advisory Board brings to the project the priorities of the community and keeps the project aligned with the true needs of the community. It serves as a bridge that links the project with the community it serves.”

Here it might be useful to go a bit deeper into what we mean exactly by “community.” One NGO leader who works with an Alliance India observed jokingly that she wished she could put a sponge against her head to suck out all the NGO jargon; in the same spirit, she even proposed a rule at her organisation that the word “awareness” should never be used in order to promote greater specificity. Jesting aside, there is truth in these statements. “Community,” like many words in the NGO lexicon, is warm and embracing, but also vague and imprecise. The concept of community may differentiate one group from another, while simultaneously recognising the integral connection between them. As important as it is to recognise the status of certain groups as marginalised, this should be done in an affirmative way. Otherwise, we can compound stigma and instead increase the barriers we are trying to overcome.

The relevance of the type of work that the Alliance does with communities to overall epidemiological impact is increasingly undeniable. For example, Dr. Chris Beyrer from Johns Hopkins University has recently shown in research in four low and middle-income countries that MSM-specific interventions had a statistically significant impact on new infections in both MSM and general populations.\(^1\) While it would be expedient to consider these populations distinct, MSM are part of general populations, and the difficulty we face in reaching MSM due to their marginalised status represents a serious challenge for the effectiveness of HIV prevention programming.

In India as elsewhere, most men who have sex with other men do not make an identity claim based on this sexual behaviour. While in the epidemiological sense these men are MSM, they lack any associated identity or community: so how can we effectively engage them in HIV prevention interventions? There are no easy answers, but we can start by reaching out to and supporting those MSM who embrace some sense of identity and

While the National AIDS Control Organisation (NACO) has done significant research relating to MSM, transgender and hijra communities, knowledge gaps remain about these communities and the HIV epidemiology within them. Pehchān has dedicated funding for seven operations research projects in five key areas, which will assist in generating knowledge that can be used to enrich programme implementation, support advocacy, and contribute to global dialogues. For example, in a national BSS study, 31 percent of MSM surveyed said they had sex with female partners in the six months prior to the survey. Our understanding of MSM and their female partners is inadequate if we are to develop responsive programming, and operations research will be used to inform the design of interventions to reach these groups.

Community, and through them, we may be able to reach some of the men who remain hidden and unserved by programming. It’s easy enough to see how the task of building programmes that are relevant and responsive is a challenge, but we should not shy away from this complexity and have the courage to admit there are still questions even as we move forward with the work. (See Box 8.)

Communities are constructed, contested, overlapping and constantly changing. India understands the key role that community plays in HIV programming. It is a guiding principle of the National AIDS Control Programme III, which is committed to “promoting social ownership and community involvement.” As part of civil society, it is our duty to engage with government policy and programme approaches to ensure they are sufficiently broad, flexible, relevant and accessible to meet community needs. By building informed programmes and delivering on results, we also have the opportunity to demonstrate priorities to policy makers.

In the end, our goal is to serve as a catalyst, enabling action without residing at its centre. As Alliance India works with communities through our Linking Organisations, and other implementing partners to strengthen their ability to plan, execute and evaluate their own programmes, we seek to become unnecessary. This is a good thing and, in fact, a real mark of our success. We need to work toward being able to pull away from communities that have achieved sufficient strength. And it doesn’t stop here; there is a multiplier effect. Community members become advocates, leaders, and teachers who in turn go on to support others. In the words of one community member, commenting on the process of engaging in a community-owned and managed initiative: “I see a ray of light in community eyes when they see me as a manager; it is as if they realise, if she can do it, so can I!”

**Jonathan Ripley**
Manager, Advocacy and Policy

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Pehchān
(2010-2015)

Named Pehchān which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme endeavours to strengthen and build the capacity of community-based organisations (CBOs) to provide HIV prevention programming for 453,000 men who have sex with men (MSM), transgenders and hijras in 17 Indian states. Pehchān is funded by the Global Fund under Round 9 and is their largest single-country grant to date focused on the HIV response for vulnerable sexual minorities.

SUB RECIPIENTS

Alliance India Regional Office
Andhra Pradesh

Humsafar Trust
Maharashtra
Gujarat
Madhya Pradesh
Rajasthan
Goa
Pehchān is working closely with MSM, transgender and *hijra* communities to establish 90 new CBOs, while strengthening 110 existing ones. To help ensure sustainability and impact, the project will help link CBOs to Targeted Interventions (TIs), a central element of India’s National AIDS Control Programme to reach high-risk groups with HIV prevention services. By supporting the development of strong CBOs, Pehchān will address some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming.

Along with Alliance India, the Pehchān consortium includes Humsafar Trust, Maan AIDS Foundation, SAATHII, Sangama, and SIAAP. These partners each work in selected states and provide organisational development, technical and capacity building support to programme CBOs.

The programme formally started in October 2010 and is actively collaborating with the National AIDS Control Organisation and State AIDS Control Societies. Activities during the first reporting period have focused on community mobilisation, development of programme governance and oversight systems, and building a strong partnership with government and other stakeholders.

<table>
<thead>
<tr>
<th>Maan AIDS Foundation</th>
<th>Sangama</th>
<th>Solidarity and Action Against The HIV Infection in India</th>
<th>South India AIDS Action Programme</th>
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<tbody>
<tr>
<td>Punjab</td>
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Pehchān will work closely with MSM, transgender and *hijra* communities to strengthen 200 CBOs in 17 states of India.
Supported by UNDP India, Sashakt was designed to build capacity and strengthen community institutions serving MSM, transgender and hijra (MTH) populations. It served as a pilot project to illustrate the effectiveness of the model proposed under Pehchān. The project developed four new CBOs and strengthened two existing ones at sites in six states: Manipur, Orissa, Uttar Pradesh, Madhya Pradesh, Maharashtra and Tamil Nadu. The overall objective of the project was to support

**Humsafar Trust**

Maharashtra: Aarambh
Madhya Pradesh: Mitr Shringaar Samiti

**Maan AIDS Foundation**

Uttar Pradesh: Sankalp
stronger CBOs for these communities to play a vital role in the national response to the HIV epidemic. Sashakt was implemented in close coordination with national and state governments.

Sashakt reached 2,374 MTH members through the four new CBOs and 2,471 through the two existing CBOs. 2,502 individuals were successfully referred for HIV testing, and 65 were found to be positive. The project responded to the needs of the community such as mental health counselling, family support, psychosocial counselling, emergency support to PLHIV, and issues of violence and trauma. These services were referred to as ‘advanced services’ and were delivered through the two existing CBOs. Almost 50% of the community served availed these services. The project also developed four training modules: identity, sexuality & gender; mental health & family support; addressing issues of female partners; and addressing issues of MTH living with HIV.

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**Solidarity and Action Against The HIV Infection in India**

Manipur: Maruploi Foundation
Orissa: Sakha

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**South India AIDS Action Programme**

Tamil Nadu: SWAM

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*Sashakt was implemented in close coordination with national and state governments.*
The Alliance Regional Technical Support Hub for South Asia (South Asia Hub) is hosted by Alliance India. From its base in New Delhi, the South Asia Hub provides technical support to nine countries in the region – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka and Myanmar. It draws upon the experience of Alliance partners and Linking Organisations from across South Asia and on a pool of technical consultants who reflect our values and commitment to excellence and quality.

Technical Expertise

The South Asia Hub’s technical expertise reflects the Alliance’s regional experience in implementing and supporting complex HIV programmes in a variety of contexts. We have particular experience with HIV programmes for Key Populations: sex workers; injecting drug users (IDUs) – especially female IDUs; MSM, transgender and hijra populations; PLHIV, orphans and other children affected by HIV/AIDS (CABA); women; and PLHIV.
India’s experience in implementing programmes is the backbone of the Hub’s capacity to provide technical support in programme management, monitoring and evaluation, financial management, and grant management, particularly on Global Fund grant mechanisms.

During the year 2010, the South Asia Hub continued on its path of consolidating its experience of working on specific thematic areas and building its strength on the provision of technical support on Global Fund mechanisms. The areas in which the Hub continues to focus include:

**Specialised Global Fund Technical Support**

The Global Fund is a performance based funding mechanism and has clearly defined performance indicators which have to be adhered to by the Principal Recipients (PR) and Sub Recipients (SR). Increasingly, civil society organisations implementing GFATM programmes are accessing technical support to improve the quality of programme implementation. The Hub undertook five regional assignments for providing technical support to Global Fund’s principal recipients and sub-recipients in Bangladesh, Bhutan, Nepal and Maldives. In Bangladesh, Nepal and Maldives the technical support was primarily on strengthening the M&E systems with a focus on Global Fund M&E indicators, performance framework, and the Monitoring & Evaluation System Strengthening Tools. In Bhutan, the Hub worked with Ministry of Health, Government of Bhutan on building their capacity on proposal development.

An important assignment connected to the Global Fund mechanism was implemented in partnership with Grant Management Solutions. This assignment provided technical support to the two of the three Global Fund Round 9 PRs in India. Under this assignment, the Hub provided technical support to two Principal Recipients of the Round 9 programme, working with migrants and Injecting Drug Users (IDU) to strengthen their programme, M&E and financial management capacities and prepare them for grant signature. The assignment assisted the PRs to meet all the condition precedents required for grant signature.

**Prevention**

The Hub conducted a situational and response analysis of HIV/AIDS among men who have sex with men and transgender populations in South East Asia. This review was aimed at systematically bringing together published and unpublished surveillance, research and programme data on MSM and TG. This has been published as a report by WHO and provides a detailed situational assessment of MSM and TG in the South and South East Asia region and also an analysis of the epidemic in the region.
Harm Reduction and Gender

Harm reduction and the injecting drug user community is another area which is Hub has identified for ongoing technical support. The harm reduction programme in the South Asia and South East Asia has primarily worked with the male IDUs but the needs of women/female injecting drug users have not been addressed to the extent desirable. The Hub with the support from UNDP BDP, New York implemented a project on building capacities of technical support providers and organisations on gender sensitive harm reduction programming. The Hub focused on building a cadre of technical support (TS) providers from South and South East Asia who will provide TS to IDU programming more gender sensitive and female friendly.

Monitoring and Evaluation

The South Asia Hub has identified M&E as one of the areas where most of the organisations would require technical support to meet the stringent reporting frameworks of most donors. As part of this endeavour, the Hub in collaboration with ICRA management and consultancy services undertook an assignment for the Process and Effectiveness Evaluation of Link Workers’ Scheme in 18 states of India. The Link Workers’ Scheme under the Global Fund Round 7 programme is an important component of the Government of India’s National AIDS Control Programme III. The assessment report prepared by the Hub helped NACO to clearly judge the differential level of programme implementation in various parts of the state. The assessment report is being used by NACO to develop strategies for improving effective delivery of the GFATM Round 7 link workers programme.

Joydeep Sen
Manager, Technical Support Hub
HIV-affected widows face a range of unmet sexual and reproductive health (SRH) needs. Widows are sexually active despite social norms and expectations of their role as widows. They are facing sexual violence within their families and communities and other violations of their sexual and reproductive rights including HIV testing and sterilisation without their informed consent.

This research brief is based on a qualitative study conducted by Alliance India among HIV-affected widows in Maharashtra, Tamil Nadu, Andhra Pradesh and Manipur. It highlights that low SRH-related knowledge levels and disempowerment prevents widows from understanding their own risks and vulnerabilities and seeking appropriate information or adopting safe behaviours. Service and information provision is currently inadequate to meet the SRH needs of HIV-affected widows – insufficient coverage and coordination between services, as well as stigma and discrimination and lack of confidentiality are acting as barriers to services.

Adolescents living with HIV face a range of unmet sexual and reproductive health (SRH) needs. While adolescents are sexually active, they have limited access to information. Adolescents show low levels of comprehensive knowledge regarding puberty, menstruation, contraception, safer sex and STIs including HIV.

Alliance India conducted a qualitative study among adolescents living with and affected by HIV in Maharashtra, Tamil Nadu, Andhra Pradesh and Manipur. This brief is based on the findings of the study aimed at underscoring the key SRHR issues around adolescents.

Adolescents consistently reported about sexual violence as an experience of their own lives or those of their peers, highlighting an immediate need for strong child protection measures. Adolescents living with HIV face additional challenges relating to their own physical development during puberty, attitudes about sexuality of PLHIV, isolation and weakened support structures, and stigma and discrimination.

Current provision of services and information for adolescents is currently inadequate to meet their SRH needs. Access to information is limited without sexuality education and information in schools and from other sources. Social norms towards adolescent sexuality, HIV-related stigma and discrimination and insufficient coverage and coordination act as barriers to services.
Launch of Alliance India website

Alliance India launched its new website – www.allianceindia.org – in January 2011. The website has helped create a unified and coherent web presence for Alliance India and has helped create greater visibility of our work. The website has helped increase awareness of Alliance India among our stakeholder community and policy makers including government, donors, and international agencies.

HIV/AIDS among men who have sex with men and transgender populations in South-East Asia

The WHO SEARO office contracted Alliance's Regional Technical Support Hub to undertake a situation analysis of HIV/AIDS among MSM and transgender populations and the national responses for them in nine South and South-East Asian Counties. This review was aimed at systematically bringing together published and unpublished surveillance, research and programme data on MSM and TG populations.

The countries included in this review are Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

This report provides information on the status of the epidemic among these populations in the South-East Asia Region. It highlights the need for improved advocacy efforts and a greater national response to save the lives of these populations who are at risk for HIV infection.

Reading Down 377: Securing the Right to Love

A number of countries continue to have laws that criminalise homosexuality. This legal architecture promotes violence and often creates significant barriers in people's live that can lead to increased HIV risk. In partnership with the Commonwealth Foundation, India HIV/AIDS Alliance produced a 12-minute documentary film called Reading Down 377: Securing the Right to Love, documenting the Delhi High Court decision in July 2009 (Naz Foundation India Trust v. NCT of Delhi).

The film highlights India as an example of a country that successfully decriminalised homosexuality. It shows the impact that the judgment had on the community, and the importance of key stakeholders from the legal, political and social spheres who played a critical role in creating the enabling environment that made the final judgment possible.

The film aims to increase understanding of legal frameworks and policies that can be implemented to increase access to HIV/AIDS treatment, prevention and care among Commonwealth government officials. It also highlights the significant role the movement itself played in mobilizing the Indian LGBT community.
We are grateful to all our donors for their growing commitment to our work. Annual income at the end of March 2011 stood at around INR 404 million, allowing us to increase grants to partner organisations to 72 percent for the period April 2010 to March 2011.

### Financial Expenditure by Fiscal Year (April-March)

*in Indian National Rupees*

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</table>

### Expenditure by Intervention

- **Prevention:** 40%
- **Care & Support:** 57%
- **Policy:** 3%

### Expenditure by Category

- **Programme Expenditure:** 23%
- **Overhead:** 5%
- **Onward Grants to Partner Organisations:** 72%

### Income by Donor

- **UNDP:** 3%
- **Gates Foundation:** 32%
- **Global Fund:** 60%
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### Board of Trustees

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<th>Position/Role</th>
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<td><strong>Rajan Mani</strong></td>
<td>Director, Finance and Operations, India HIV/AIDS Alliance</td>
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<tr>
<td>(India)</td>
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<td>Chair of the Alliance Board, former Director-General of the International Planned Parenthood Federation</td>
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<td>(United States of America)</td>
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India HIV/AIDS Alliance

The India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organisations and communities to support sustained responses to HIV in India. Complementing the Indian national programme, we work through capacity building, knowledge sharing, technical support and advocacy. Through our network of partners, Alliance India supports the delivery of effective, innovative, community-based HIV programmes to key populations affected by the epidemic.

Alliance India also hosts the Alliance Regional Technical Support Hub for South Asia, which provides technical assistance to strengthen local responses to HIV & AIDS and improve programme implementation.

India HIV/AIDS Alliance
Kushal House, Third Floor, 39 Nehru Place, New Delhi - 110019
Phone: +91-11-4163-3081 Fax: +91-11-4163-3085
www.allianceindia.org