CHAHA PROGRAMME

ANNUAL REPORT
(2009-2010)
<table>
<thead>
<tr>
<th>CONTENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>2</td>
</tr>
<tr>
<td>About Alliance India</td>
<td>3</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>4</td>
</tr>
<tr>
<td>Message From The Country Director</td>
<td>5</td>
</tr>
<tr>
<td>Understanding The Problem</td>
<td>6</td>
</tr>
<tr>
<td>CHAHA Programme – Alliance India’s Response</td>
<td>7</td>
</tr>
<tr>
<td>to the Specific Needs of Children</td>
<td></td>
</tr>
<tr>
<td>Achievements</td>
<td>11</td>
</tr>
<tr>
<td>Beyond The Targets</td>
<td>20</td>
</tr>
<tr>
<td>Lessons Learned</td>
<td>33</td>
</tr>
<tr>
<td>Programme Management</td>
<td>35</td>
</tr>
<tr>
<td>Financial Summary</td>
<td>37</td>
</tr>
<tr>
<td>Alliance India’s CHAHA Partners</td>
<td>38</td>
</tr>
</tbody>
</table>
Acknowledgements

The India HIV/AIDS Alliance (or, Alliance India) is implementing The Global Fund Round 6 supported CHAHA programme in four states – Andhra Pradesh, Maharashtra, Manipur and Tamil Nadu. Through partners in these states, CHAHA programme offers a comprehensive community based care and support programme and has been able to reach over 50,000 children and families till date in both rural and urban areas.

Alliance India is happy to acknowledge the notable contribution made by the 9 sub-recipients (SR) and 59 sub-sub-recipients (SSR) for significantly enhancing the wider understanding of programme efforts related to care and support services for children infected and affected by HIV. The SR and SSR have done tremendous work in achieving the objectives and targets in terms of the performance framework of CHAHA.

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

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

For more information on the India HIV/AIDS Alliance and its work, please visit our website www.aidsalliance.org and to access Alliance India’s resources and publications, please visit our knowledge portal - Setu - on www.aidsallianceindia.net, or write to:

India HIV/AIDS Alliance
Kushal House
39 Nehru Place
New Delhi 110019

India HIV/AIDS Alliance
Telephone : +91 11 41633081
Fax : + 91 11 41633085
Email : info@allianceindia.org
India HIV/AIDS Alliance (or Alliance India), a part of the International HIV/AIDS Alliance (or Alliance), began its operations in 1999 to expand and intensify the Alliance’s vision and mission, and to mitigate the adverse impact of Acquired Immuno-Deficiency Syndrome (AIDS). For over a decade now, Alliance India has been a leader in fostering and supporting the development of community-driven approaches to HIV prevention, care and support, and impact mitigation. Alliance India recognises that reducing stigma and discrimination, particularly among the most vulnerable and marginalised communities is key to the epidemic – sex workers, Men who have Sex with Men (MSM), Injecting Drug Users (IDUs) and adults and children living with and affected by HIV – and fundamental to an effective response to HIV and AIDS. It has made significant efforts towards reducing stigma and discrimination by building a network of four strong national intermediary organisations, known as Linking Organisations (LOs), in the states of Andhra Pradesh, Tamil Nadu, Maharashtra and Delhi, setting up a project office in Andhra Pradesh, and collaborating with a state partner in Manipur. These Alliance India partners, in turn, work in partnership with their networks of over 100 community-based nongovernmental organisations (NGOs) and community-based organisations (CBOs). Alliance India supports these organisations by providing financial and responsive technical support, skills building, policy, and programmatic and organisational development inputs.

Alliance India is also a member of the Regional Technical Support Hub (TSH) to support Alliance programmes in South Asia. The core purpose of the TSH is to build national and regional capacity to respond effectively to HIV and AIDS. TSH provides services and uses approaches that strengthen country and local partners’ capacity to manage technical assistance effectively. Through this capacity building, TSH is able to provide sustainable technical assistance in programme planning, research, monitoring and evaluation, knowledge management, financial management and budgeting and advocacy. The specific themes where it provides technical assistance includes community and home based care, prevention strategies with most at risk populations (MARPs), treatment, care and support for HIV and AIDS, gender response to drug use and HIV, sexual and reproductive health and tuberculosis. The TSH has a well-established and quality assured database of consultants who work with the Alliance in the Asia region.

Alliance India’s advocacy work aims to influence policies and increase funding. Its network building strengthens the capacity of the Alliance across India. Quality communication increases attention to ensure all interventions are effective to meet community needs. It also gives special emphasis on Knowledge Management functions to strive to share learning and help replication, conduct operations research and best practice documentation to feed into the programmes, and support policy and advocacy initiatives.
Abbreviations

AIDS : Acquired Immuno-Deficiency Syndrome
ART : Anti Retroviral Therapy
CAA : Children Affected by AIDS
CABA : Children Affected by AIDS
CBO : Community Based Organisation
CLHIV : Children Living with HIV
CPR : Country Progress Report
DAPCU : District AIDS Prevention and Control Units
EID : Early Infant Diagnosis
GAWA : Global AIDS Week of Action
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 Services
ICTC : Integrated Counselling and Testing Centre
LO : Linking Organisation
LSE : Life Skills Education
MoU : Memorandum of Understanding
MWCD : Ministry of Women and Child Development
NACO : National AIDS Control Organisation
NACP : National AIDS Control Programme
NGO : Non-Governmental Organisation
NREGA : National Rural Employment Guarantee Act
OI : Opportunistic Infection
ORW : Outreach Worker
PHC : Primary Health Centre
PLHIV : People Living with HIV
PPTCT : Prevention of Parent to Child Transmission
PR : Principal Recipient
PRI : Panchayati Raj Institutions
SACS : State AIDS Control Society
SDA : Service Delivery Area
SHG : Self Help Groups
SR : Sub-Recipient
SRH : Sexual and Reproductive Health
SSR : Sub Sub-Recipient
TSH : Technical Support Hub
TNSACS : Tamil Nadu State AIDS Control Society
TNTCAA : Tamil Nadu Trust for Children Affected by AIDS
UNGASS : United Nations General Assembly Special Session
Drafting the CHAHA annual report is an inspiring and thought-provoking process. It is inspiring because it gives us the opportunity to reflect on the programme’s successes—the tens of thousands of children living with and affected by HIV who have access to essential support; communities more sensitive and responsive to the needs of these children and their families; and an increased commitment from government to improve and expand support for them. Yet, even as we mark these successes, we must also consider the many challenges that remain.

This year’s CHAHA annual report describes our progress in supporting effective care and support services for children affected by HIV and AIDS but it is also fully mindful of what remains to be done during the last phase of the programme, scheduled to end in early 2011. Our work has always been informed by a high level of urgency, and even as we enter this close-out period, we will continue with similar energy to achieve our targets and develop sustainable linkages to ensure that CHAHA children and their families have access to quality of services and support.

CHAHA endeavours to mitigate the adverse impact of HIV and AIDS by directly addressing issues such as inadequate household income and the additional burdens of nutrition and treatment for children living with HIV, as well as the social isolation and stigma caused by HIV. The programme provides short-term nutritional and emergency support to meet immediate needs of families. Working with the government and other agencies, we need to expand responsive emergency support and strengthen systems for affected families.

CHAHA has focused on sustaining certain benefits of the programme by linking families with government initiatives. This year saw significant success in establishing linkages with government welfare schemes and entitlements. The commitment from concerned government departments to provide supplementary nutrition through Integrated Child Development Scheme (ICDS) and mid-day meal programmes will ensure continued nutritional support to children living with and affected by HIV. Increasing access to early infant diagnosis and cotrimoxazole prophylaxis will also help prevent opportunistic infections and prolong life. Sensitisation programmes at community level and with service providers have led to an increasingly supportive and enabling environment.

This year, 25,151 children were enrolled in CHAHA. Again and again, children and families report that the programme has been a turning point for them and their families, easing their social exclusion and giving them new hope. None of this would be possible without our outreach workers and volunteers at the community level, whose untiring efforts have been essential to the programme’s continued success.

In closing, I would like to take this opportunity to thank the Global Fund for its generous support of CHAHA and our implementing partners for their ongoing commitment to the programme and their many contributions to its success.

James Robertson
Country Director
India HIV/AIDS Alliance
Understanding the Problem

The 2008 estimate in India for national HIV prevalence is around 0.29 percent, which amounts to 2.3 million people, most of who are located in high prevalence districts in South and North-East India. An estimated 94,000 children are living with HIV and an estimated 57,000 children are infected every year through vertical transmission. A total of 63,889 CLHIV are registered at the ART centre, of which 18,763 have ever received ART as on January 2010 (Country Progress Report - CPR - for UNGASS, India, 2010).

HIV progresses very rapidly in young children, especially in the first two years of life, often leading to death. HIV infected infants frequently present with clinical symptoms in the first year of life. Without care and treatment, about one third of infants living with HIV will die in their first year of life and almost 50% of children by the second year of life. Asymptomatic HIV exposed children under 18 months old are not diagnosed, and therefore do not get the benefit of prevention, care, support and treatment services.

It is not uncommon for children from families affected by HIV and AIDS to drop out of school due to stigma or to take care of sick parents and/or take up gainful employment to support the families. This in turn leads them to join the ‘vulnerable’ children /adolescents who are at risk of acquiring HIV infection. Reducing the vulnerabilities of CLHIV and CAA requires a systemic change for an effective response to the needs of these children.

The National AIDS Control Programme, Phase III (NACP-III) has recognised the unmet needs of CLHIV and CAA and has given due importance to scale up child focussed services. The strategies include early diagnosis and treatment, comprehensive paediatric HIV care, enhancing capacities of counsellors for counselling CLHIV and CAA, outreach and transportation subsidies to access ART, follow-up to promote treatment adherence, and nutritional, educational and skill development support. It also involves developing linkages with social sector programmes for enforcing minimum standards of care and protection in institutional and community based care and support for children.
In 2000, when Alliance India initiated an Abbott Fund supported Home and Community Based Care and Support (HCBCS) programme through partner organisations in the states of Tamil Nadu, Andhra Pradesh and Delhi, it set a pioneering trend in providing home based care and support to PLHIV and their families. In 2007, it continued its special focus on children with CHAHA, a project designed to mitigate the adverse impacts of HIV and AIDS on children based on its experience from the Abbott Fund supported programme, a baseline survey and strategic priorities of National AIDS Control Programme – III (NACP-III). Alliance India is the civil society Principal Recipient (PR) under Round 6 of the Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM) for implementing the CHAHA programme. By the end of third year, Alliance India is implementing CHAHA in partnership with a consortium of 9 Sub-Recipients (SR), and 59 Sub-Sub-Recipients (SSR).

Main approaches

CHAHA aims to provide care and support to 64,000 children affected by HIV and their families, especially the women-headed families, residing in 41 districts in the states of Maharashtra, Andhra Pradesh, Tamil Nadu and Manipur. Alliance gives significant emphasis on community-driven response to HIV and believes that active involvement of the family and engagement with the community leadership is a prerequisite for any HIV intervention. The programme therefore focuses on working closely with various stakeholders and government ministries to ensure that the children remain with their parents or extended families. CHAHA also adopts a holistic approach to respond to the needs of the CLHIV/CAA and provides integrated services for the child and the family in which the child lives, which is an integral part of the community.

CHAHA adopts three main approaches for the wellbeing of CLHIV/CAA and their families:

a. Create a supportive environment through community mobilisation in all settings for stigma and discrimination reduction through direct services and advocacy,

b. Strengthening and capacity building of NGOs and CBOs, and

c. Strengthening information systems and conducting operational research.
Implementation strategies

The central focus of CHAHA programme is the affected families and efforts are made to ensure that they remain integrated with the community in order to increase effectiveness of various services essential for mitigating the adverse impacts of HIV and AIDS. It also creates a conducive and supportive environment sans stigma and discrimination for the children and their families. CHAHA’s comprehensive package of care and support services to the affected children and families includes four main service delivery areas (SDA) which are summarised in Figure 1:

SDA 1 – To improve care and support services to children living with and/or affected by HIV and AIDS: Children and their families are given a comprehensive package of care and support. Key components of this service delivery area include referral and linkages to HIV related treatment, care and support services, other medical care, nutritional support, providing assistance for immediate needs of the children and families, educational support, income generation support and psychosocial support for CLHIV and CAA.

SDA 2 – To create a supportive environment for reducing the stigma and discrimination: Sensitisation of the community, service providers and other stakeholders is an integral part of CHAHA. A more response community results in reduced stigma and discrimination and makes it easier for CLHIV, CAA and their families to live with dignity and access various HIV and AIDS related and other welfare services.

SDA 3 – To create a supportive environment for strengthening of civil society and institutional capacity building: CHAHA lays special emphasis on enhancing capacities of staff and organisations at every level of implementation and establishes linkages with various government and non-government agencies for strengthening infrastructure, systems and human resources in prevention, treatment and care and support. The partnerships at different levels facilitate a multi-sectoral response by engaging a wide range of stakeholders in private sector, civil societies, PLHIV networks and various ministries and departments of the government.

SDA 4 – Information systems and operational research: A strategic information management system for monitoring and evaluation at all levels is fundamental to an effective programme implementation. CHAHA indicators and data collection are in conjunction with the national requirements and the data is shared at district, state and national levels. Areas for operations research are identified through a consultative and analytical process involving various national level stakeholders, SR and SSR to strengthen the programme and give

Figure 1: Comprehensive framework of services provided by CHAHA
Overview of the programme in year 1 and year 2 (2007-08 and 2008-09)

Alliance India’s experience of HCBCS programme for PLHIV and their families has given an insight into gaps in services for CLHIV and CAA while the CHAHA baseline study helped assess specific issues of affected children and their families in the programme areas. Involvement of the community right from the inception had played a vital role in providing need-based and timely support to the children and the families. CHAHA has kept the affected families at the centre of its interventions and ensured that the families remain an integral part of the community. This helped not just in effectiveness of the services to mitigate the adverse impacts of HIV in terms of improving health-seeking behaviour but also helped create a conducive and supportive environment for the children and families. The comprehensive package of services was found to be relevant for the children and their families. Some partners however had preferred to integrate the children in the community rather than facilitate foster care.

By the end of Year 1 (2007-08), the programme had gained several experiential insights. The programme staff’s role in improving access of the children and families to government welfare schemes was highlighted, the challenges of reaching the children and families in remote, difficult to access regions began to surface. It also became evident that the proposed investment in child support group was inadequate. It was felt that strengthening such support groups by increasing child centric group activities such as use of arts and crafts and life skills education was a priority. CHAHA partners also knew that ensuring long-term sustainability required looking beyond provision of direct services. Linking the children and families with government agencies and schemes required fulfilling the government’s procedural requirements, for which most families lacked supportive documents.

There were other challenges faced by the programme. Within six months of the programme, the US dollar depreciated significantly, making it difficult to support the programme for the entire
duration. The cost of travel had increased and the field staff to needed were needed to travel longer distances to achieve the targets. The NACP guidelines for salaries of field staff were modified by the end of Year 1 of the programme and the partners felt compelled to match the staff salaries in order to avoid trained staff attrition. These compelling reasons led to reduction of Phase I of the project from 24 months to 19 months and Phase II from 36 months to 24 months. The revised targets for each quarter based on the changed duration of programme is as shown in Figure 2.

The number of beneficiaries reached during Year 2 and Year 3 was two and three times respectively more than the numbers covered in Year 1. This meant significant challenges for providing quality services to an increased number of children and their families. Year 1 experience had also indicated that the demand for services was more extensive and more time intensive than what was envisaged during the design phase.

Increase in the number of outreach workers: To meet the increasing demand of targets and quality of services, the ratio of children to outreach worker (ORW) was changed from 75:1 to 60:1. Newer ORWs were recruited in three phases to correspond with the increase in targets.

Induction of Volunteers: PLHIV living a positive and healthy life were inducted as community based Volunteers. They acted as drivers of change at community level and increased the interface between the programme and the general community.

Appointment of Assistant Project Coordinators: An additional post of Assistant Project Coordinator was created to support the Project Coordinator at SSR level in managing human resources, advocacy and computerized management information systems (CMIS).

Figure 2: Targets of CHAHA programme
The third year of CHAHA programme (July 2009 – June 2010) saw acceleration of its journey to mitigate the adverse impacts of HIV and AIDS on children by building on the trend of increasing demand for services observed during the previous two years, and forged stronger ties of trust and partnership with the beneficiaries and the communities. In addition to achieving increased targets and continuing to provide quality services to children and their families, the SR and SSR began to invest significant time to explore strategies for sustaining the programme and its benefits. This chapter focusses on key achievements at national and state levels and against the set targets for various programme components during Year 3 (2009-10) of CHAHA. Achievements during the first two years of the programme have been described in the Year 1 (2007-08) and Year 2 (2008-09) annual reports of CHAHA.

Increased focus at national level

The issues of children affected by HIV and AIDS are now being focussed at national level because of the growing recognition of a gap in the existing programme. Alliance India has played a vital role in engagement with various stakeholders for ensuring that the CAA are considered a priority. CHAHA partners have also been in the forefront for advocating the rights and highlighting the special needs of CAA at the state and district levels. Alliance India has been an active member of the national task force for children affected by AIDS (CABA) to implement the “Children and AIDS policy” in India. Alliance India played significant role in conceptualising and designing the CABA scheme, which is a pilot scheme being implemented since May 2010 in 10 high prevalent districts in Andhra Pradesh, Tamilnadu, Maharashtra, Manipur, Karnataka and Delhi.

Achievements

The Government of India (GOI) recognises the CHAHA programme as one of the important initiatives for children and has fostered a partnership with Alliance India and issued a letter to State AIDS Control Societies (SACS), Regional coordinators, ART centres, and Integrated Counselling and Testing Centres (ICTCs) to roll out the Early Infant Diagnosis (EID). The draft guidelines developed by NACO recommend:

- ARV prophylaxis post delivery within 72 hours (as part of PPTCT regimen to give prophylaxis to mother-baby pair)
- Cotrimoxazole prophylaxis for all HIV-exposed infants and children born to HIV positive mothers from 6 weeks of age (coinciding with the first immunization visit) until HIV infection is reliably excluded.
- HIV testing to determine HIV status of the infant/child: HIV DNA PCR or antibody depending on age of the infant/child
- Regular follow-up for clinical, development and growth monitoring
- Immunisations as per the national/state schedule
- Nutrition counselling for parents/caregiver to ensure appropriate infant feeding practices including weaning and complementary feeding
- ART and other treatment when indicated

Operationalisation of the EID guidelines for HIV exposed infants and children below eighteen months requires strong linkages and referrals from the various health facilities from districts and sub districts to specialised services such as ICTC, ART centres and Paediatric departments. CHAHA partners educate and mobilise the communities to take their children for DNA PCR testing to ICTCs where EID facilities are available. NACO shared the list of ICTCs with Alliance India, which in turn shared it with SRs and
SSRs to establish linkages with the ICTCs. SRs and SSRs were also trained on EID guidelines and the importance of early diagnosis for HIV exposed children. NACO also informed SACS in four CHAHA states about Alliance India’s role in supporting EID roll out, which resulted in enhanced support from SACS.

Increased response at state levels

All the states where CHAHA is being implemented have shown an increasing response to the special needs of CLHIV and CAA. In Andhra Pradesh, one Gram Sabha (village level administrative body), has passed a resolution to eliminate stigma and discrimination against children and families affected by HIV and AIDS. CLHIV in Maharashtra have increased access to ART services. They have also been given adequate support for adherence including assigning adherence calendars. The advocacy efforts in Manipur have resulted in an upward trend in demand for social welfare schemes of the government. Tamil Nadu has demonstrated increased coordination between the CHAHA partners and local private doctors who refer children to the programme.

The CABA scheme is being implemented in four CHAHA programme areas – Krishna district in Andhra Pradesh, Salem district in Tamil Nadu, East Imphal district in Manipur, and Sangli district in Maharashtra. The District AIDS Prevention and Control Units (DAPCUs) are implementing the programme and SRs/SSRs in the respective districts provide support to DAPCUs in identifying staff to implement the CABA scheme, line listing of children, conducting baseline survey, district situation assessment and mainstreaming the CABA with other departments’ schemes/programmes. DAPCUs, Regional Coordinators and SRs/SSRs were trained on CABA scheme and its implementation. After the training, SACS, DAPCUs and SSRs signed a memorandum of understanding (MoU) detailing specific responsibilities for each stakeholder. As a follow up to the training, DAPCUs and SSRs had meetings with the district collector whose responsibility is to convene monthly meetings of DAPCU, SSRs, and other departments, and review the number of children linked to services. Alliance India provides technical support to SACS and DAPCUs on various issues of CABA such as nutrition, education, protection and working with government departments especially women and child development, education and social welfare.

Rapid increase in enrollment of beneficiaries

Total number of children enrolled in the programme during Year 3 was 25,151, bringing the total number since inception of the programme to 49,040 (Figure 3). The enrollment during Year 3 was 39.2% of the total target of 64,000 children and the enrolment till date is about 76% of the total target. The total enrollment by the SSR during Year 3 was 3.04 times more than Year 1 and 1.6 times more than Year 2. The rapid increase in number of children enrolled with each subsequent year of the programme indicates increasing demand from the community and greater level of confidence in the programme. The programme has been able to meet the targets set for it by Global Fund despite the quarterly targets having been significantly increased due to the reduction in the total duration. Reports from SR and SSR indicate that the demand for enrollment in the programme is higher than the targets, which necessitated selection of beneficiaries with greater need for support.

Figure 3: No. of children enrolled during the last three years
Key outcomes

In terms of targets, CHAHA programme achievement was more than 100% for eight of the ten targets except for number of CLHIV referred for paediatric ART (72.9%) and number of households receiving income generation support (98.4%). The greater emphasis on increasing community ownership was indicated by 140% achievement in number of participants attending community based sensitisation meetings and 121.7% achievement for number of Children Support Groups formed. Quality of service delivery is greatly dependent on the performance levels of programme staff. CHAHA demonstrated its continuing commitment to quality through 124.1% achievement of its target for training of NGO and CBO staff (Table 1). The key outcomes, however, go much beyond the numbers, and encompass a wide range of ways by which the lives of the children and their families have been enriched.

Referrals and linkages

Limited knowledge, fear of disclosure, fear of discrimination in healthcare settings and paucity of resources make it difficult for people to access existing health services. Sensitisation of healthcare providers by CHAHA partners has ensured client friendly HIV related services. Establishing referral linkages and community networks in the programme areas continue to be the main source of information and contact point to reach children and their families. Linkages have been established with integrated counselling and testing centres (ICTC), auxiliary nurse midwives (ANMs), accredited social health activists (ASHA), anganwadi workers (AWW), positive networks and ART centres in each programme area, which has helped identify children and families in need of support. Programme data shows an increase in number of referrals from the community, which is a testimony to the success of the programme. CHAHA has also continued its efforts to maintain gender balance in enrolment of children and about 48% of the beneficiaries are girls.

Table 1: Achievements for CHAHA programme indicators (July 2009 – June 2010)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Till Year 2</th>
<th>During Year 3</th>
<th>Total Year 1-3</th>
<th>Target</th>
<th>% of target</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of CLHIV and CAA benefiting from a minimum package of care and support services</td>
<td>23,889</td>
<td>25,151</td>
<td>49,040</td>
<td>49,000</td>
<td>100.1</td>
</tr>
<tr>
<td>No. of CLHIV and CAA receiving nutritional services</td>
<td>9,805</td>
<td>9,911</td>
<td>19,716</td>
<td>19,600</td>
<td>100.6</td>
</tr>
<tr>
<td>No. of households of CLHIV and CAA covered by basic support</td>
<td>12,417</td>
<td>13,130</td>
<td>25,547</td>
<td>24,500</td>
<td>104.3</td>
</tr>
<tr>
<td>No. of children referred for paediatric ART</td>
<td>1,032</td>
<td>754</td>
<td>1,786</td>
<td>2,450</td>
<td>72.9</td>
</tr>
<tr>
<td>No. of CLHIV and CAA provided with educational support and/or vocational training</td>
<td>4,028</td>
<td>4,056</td>
<td>8,084</td>
<td>7,820</td>
<td>103.4</td>
</tr>
<tr>
<td>No. of households provided income generation support</td>
<td>2,404</td>
<td>2,418</td>
<td>4,822</td>
<td>4,900</td>
<td>98.4</td>
</tr>
<tr>
<td>No. of child support groups formed</td>
<td>423</td>
<td>323</td>
<td>746</td>
<td>613</td>
<td>121.7</td>
</tr>
<tr>
<td>No. of sensitisation meetings held in communities</td>
<td>1,414</td>
<td>1,054</td>
<td>2,468</td>
<td>2,290</td>
<td>107.8</td>
</tr>
<tr>
<td>No. of participants attending community level sensitisation meetings</td>
<td>17,484</td>
<td>14,813</td>
<td>32,297</td>
<td>22,900</td>
<td>141.0</td>
</tr>
<tr>
<td>No. of NGO/CBO staff trained</td>
<td>1,907</td>
<td>2,718</td>
<td>4,625</td>
<td>3,727</td>
<td>124.1</td>
</tr>
</tbody>
</table>
Regular follow-up of all CLHIV and PLHIV was done to assess their health status, registration at the ART centre, commencement of ART and issues of adherence. HIV positive mothers were encouraged to get their children tested for HIV, which led to an increase in identification of CLHIV and their registration at the ART centre. Target achievement for this indicator was 72.9%. Number of children referred for paediatric ART since the initiation of the programme was 1,786, of which 754 were registered during the current year (Figure 4).

With each year of the programme, the number of CLHIV enrolled has increased, and so has the number of CLHIV who have lived longer with HIV. It was therefore expected that the number of CLHIV requiring ART would increase. Analysis of the programme data however indicates that the percentage of children requiring ART has remained around 25% during the last three years. This is yet another testimony to the effectiveness of the programme as it is postponing the requirement for ART.

The percentage of CLHIV among all children registered for the programme has reduced from 16.8% in Year 2 to 14.3% in Year 3, which may have also contributed to deficit in meeting the target for referral for paediatric ART.

CHAHA recognises the value of early diagnosis and management of HIV in babies born to HIV positive mothers. It had therefore initiated advocacy initially at national level, and then at state and district level to promote systems for early infant diagnosis (EID) and cotrimoxazole prophylaxis for HIV exposed infants. The outcome of this advocacy will have an impact far beyond the project period, especially when the service providers and the community become aware of the importance of early diagnosis and prophylaxis in HIV exposed children.

**Nutrition support**

It is undisputable that lack of adequate and balanced nutrition compounds the problems of HIV, especially in terms of treatment and health outcomes. The impact of poor nutrition is especially critical due to the additional nutritional demands for growth and development. The programme met its target for nutritional services including nutritional counselling and demonstration services. Each child’s need for supplementary nutrition was assessed based on the child’s health, family background and the economic status of the family.

Supplementary nutrition was provided directly through programme funds and indirectly through linkages and networking with government departments, various social welfare schemes, individual donors, and community groups such as Lions Club, Rotary International and others. Nutritional demonstration was also done using locally available food materials to facilitate easy adaptation of the proposed nutritional practices by the families. Families were linked with more sustainable resources such as Integrated Child Development Services (ICDS), midday meals

![Figure 4: No. of children referred for ART](image-url)
and public distribution systems (PDS). The number of families given nutritional support this year was 9,911.

Experience during the first two years of the programme had indicated that despite nutritional support and linkages with existing government schemes and services, CLHIV and CAA were often unable to get the nutrition required for their overall growth and development, and for reducing the risk of infections. CHAHA’s successful advocacy on giving double nutrition to pre-school children through the anganwadis has helped meet the nutritional requirement of the children. There is a growing awareness of the special provision for CLHIV and CAA in anganwadis among the ICDC functionaries and the community, which will ensure sustainability of nutritional support beyond the programme.

**Education support**

CLHIV and CAA often experience disruption in their formal education due to factors ranging from poor health, inadequate resources, loss of parents or stigma and discrimination.

CHAHA programme continued its emphasis on the continuing education of the children. The barriers for continuity of education that inhibit children from attending school were addressed through various forums and innovative approaches. Dropouts were readmitted in the schools, and school authorities and community leaders were sensitised to take proactive measures to prevent acts of stigma and discrimination. Support was 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. The children were also linked with other educational programmes and schemes such as scholarships, discounts and fee waivers wherever necessary and possible. During this year, 4,056 families had received educational support or vocational training.

**Psychosocial support**

HIV has a profound impact on the children, especially since they lack the coping mechanisms of adults. Special skills are required to help the children deal with their issues and express their feelings and needs. CHAHA outreach workers and counsellors provided periodic need-based counselling support to children and their families through one-to-one interactions and field visits. The programme continued its special focus on promoting children support groups to provide a platform for children to share, express and learn from each other. Inclusion of Life Skills Education (LSE) in the support groups meetings has been effective and has helped in their overall development, reduced isolation, helped them bond with other children and given them confidence to express their feelings, likes and dislikes. The number of new support groups established during the year was 323 (Figure 5), which was 26 more than in the previous year and about 2.5 times more than in Year 1.

![Figure 5: No. of child support groups established](image)
Family support

The family support focussed mainly on providing financial and other assistance for the family’s emergency needs and for a wide range of income generation activities (IGA).

Emergency support: The needs of the children and families affected by HIV are varied. The most flexible component of CHAHA is to give household support for emergency needs. Sometimes, support is also given for basic needs of the families and children. Priority is given to those who are sick and unable to work, orphans living with grandparents and children of widows. Number of families who received emergency support was 13,130, which included financial support for medical expenses, utensils, clothes, travel for CD4 testing and accessing ART centre, house repair, roof sheets and water filters. The household support has helped not just to improve the quality of the caregiver’s life and prolong their life but has also improved family environment, which is critical for the children’s emotional security and stability.

Income generation support: Families affected by HIV generally suffer deterioration or complete loss of income due to illness or death. This amplifies a myriad of related concerns such as malnutrition, increased morbidity, discontinuation of children’s education, poor utilisation of health services, etc. This is why the support for income generation activities is an important component under CHAHA. Such support helps the affected families become economically independent, ensures comprehensive development and reduces reliance on welfare schemes.

Income generation support was provided to 2,418 needy families, achieving 98.4% of the target for this indicator. Revolving funds set up by many partners during the previous year have been effective and the families supported through the fund have started returning the loan amount, which has allowed giving loans to other needy families. A large number of families reached through the programme are now economically self-reliant. Another strategy that has worked is involvement of more than one family member in income generation activities.

TIMEly ACTION RESTORES RIgHT TO EDUCATION

12th August 2009 is a date eight young children studying in a primary school at Ajangavon Bari, Amravati district, are not likely to forget. They are also not likely to forget Independence Day that year, as it gave them freedom – from prejudice, stigma and discrimination. All the eight children were HIV positive and were terminated from the school on 12th August 2009 because of intense pressure from parents of other children, who threatened to boycott the school unless these children were rusticated.

The children were either orphans or had a single parent, and had little access to basic amenities. They were therefore being looked after by Navjeevan, a children’s home managed by Jeevan Vikas Sanstha, one of the SSR. Fortunately, the CHAHA team had already developed rapport with, and sensitised various government department officials. On the day of protest from the parents of other children, the head mistress of the school and staff of Navjeevan accompanied the CHAHA workers to request the Block Development Officer (BDO) to address the issue. The BDO and other officials concerned visited the school and met the Gram Panchayat Sikhsan Samti, Sarpanch, UpSarpanch and other elders of the village, who responded positively. Three days later, on Independence Day, a sensitization meeting was held in the village, which was attended by other government officers and a doctor’s team led by the district Civil Surgeon. The visitors clarified the doubts about HIV and AIDS among the parents and other community members, especially about HIV transmission. The meeting ended with a commitment from the youth of the village, SHGs and parents of the other school children to do their best to support these eight children to continue their education.
generation activities as it allows continued income even if one of them is unwell. Financial support has been given for a wide range of activities such as setting up petty shops, provision shops, vegetable shops, tailoring units or flower stalls, buying sewing machines, iron boxes, starting tiffin centres, retailing fodder or fancy items and making leaf plates.

Reducing stigma and discrimination

Reports of stigma and discrimination in the programme areas have decreased during the last three years. However, stigma and discrimination continues to prevail that results in denial of admission in schools, denial of treatment, especially surgical and obstetric treatment, and limited employment opportunities. CHAHA recognises that involving the community is essential for reducing stigma and discrimination. This is why the SSRs have continued to mobilise the community, conduct awareness and sensitisation programmes, do advocacy at community, district and state levels and establish linkages with positive networks.

During the year, overachievement of this indicator (107.8%) was the result of new staff at SSRs and better coordination for conducting the sensitisation meetings. Training in Advocacy had Skills helped strengthen this component, the outcome of which was 1,054 meetings during the year – almost the same as the previous year and 2.71 times more than the first year of programme (Figure 6).

Bhanumathi (name changed), a nine year old resident of Sankari village in Salem district, was too young to appreciate the valuable life’s lesson her grandmother had recently learned – a supportive community is the most precious asset in life. Bhanumathi and her two younger siblings live with their grandmother, a daily wage labourer, and an uncle ever since their mother died of AIDS related illness two years ago and the father abandoned them. Her uncle did not want the three girls to live with him and often forced his mother to move out with the girls. They could not have done so as they had no other place to live. Early in 2010, he finally threatened them with dire consequences if they did not vacate the house within a month. Despite several please by ORWs of WORD, the SSR working in the area, and the community elders, her uncle refused to relent.

The ORWs learned that the grandmother owned a small piece of vacant land, and began planning for a home for the little girls. The grandmother welcomed the idea but was apprehensive, as she had no resources to build even a small dwelling. Although the ORWs arranged for funds to be released from the CHAHA programme to purchase hollow bricks, the need was for much more. The ORWs therefore began mobilising the community. After considerable effort, the community leader offered to buy some materials for house construction. This was followed by the offers of free labour and additional construction material from a few relatives and several community members. As Bhanumathi watched her home being built brick by brick, her grandmother was at peace. The three girls will never be without the support – they have a large and supportive family, even though many of them are not relatives.

**Figure 6: No. of sensitisation meetings held**
Sensitisation of the staff at Primary Health Centres (PHC) continued and special efforts were made to strengthen linkages with various district level departments (such as education, health, women and child development), Panchayats, Block Development Officers, District Hospital Superintendent, Nodal Officer ART Centre, and District Project Manager – National Rural Health Mission). As a result, an increasing number of children are being linked to the government schemes and services. A new and successful initiative has been working with the Children Welfare Committees at the district level, which have begun to collaborate with CHAHA programme for the common goal of addressing issues of children affected by HIV.

A significantly higher achievement of this target (141%) indicates increase community involvement and greater degree of sensitivity towards CLHIV and CAA. Advocacy strategies developed collectively by Alliance India, SR and SSR for providing double nutrition to CLHIV and cotrimoxazole prophylaxis for children under five years had also helped in winning the confidence of the community. The number of participants attending the sensitization programmes during the third year was 14,813, which was marginally higher than the second year participation and about 3.7 times more than in the first year (Figure 7).

**Capacity building**

CHAHA gives due emphasis to strengthening civil society and institutional capacity building by enhancing the capacities of the staff and organisations at every level of implementation. The linkages with NACO, SACS and other government and non-government agencies were strengthened during the year. CHAHA has kept in mind the mandate of NACP-III of strengthening infrastructure, systems and humans resources in prevention, treatment, and care and support at every level.

A total of 1,406 volunteers and outreach workers had received training during the year, which indicated CHAHA’s commitment to quality service delivery. The focus of these training programmes was on reinforcing knowledge about HIV and AIDS, clarifying persistent doubts, ART and its adherence, cotrimoxazole prophylaxis, referral and linkages and home based care for adults and children.

*Figure 7: No. of participants attending sensitisation meetings*
Management information system

During the first two year of the programme, monitoring and evaluation (M&E) was done through maintenance of various records by SSR, which was compiled in excel sheets by the SR and submitted to Alliance India, the PR. This system did not allow effective tracking of every child and every activity till the end of the project. Alliance India therefore developed a computerised management information system (CMIS) in 2009. By the end of the Year 3 of the programme, all the relevant SSR staff were trained in the use of the software and had started using it for their monthly reporting.

The CMIS has four main features:

• It allows tracking of all registered children in CHAHA programme along with the services provided to them. This output can be generated at SSR, SR and PR levels.

• It generates a wide range of analytical outputs based on the data at SSR level, which will specific needs of each child. All the SSR can therefore take corrective measures, if any, to strengthen specific programme components and meet precise requirements of the beneficiaries.

• It allows consistent review of the progress at any time, unlike the earlier review at the end of every quarter. This can ensure timely remedial measures, if any.

• It provides error free, consistent and timely data flow from SSR to SR and then to PR.

CMIS was a major step towards quality assurance at all levels.
Beyond the Targets

The major thrust during Year 2 was on scaling up the numbers and reaching quantitative targets. It was a period of testing CHAHA’s and its partners to identify and select needy CLHIV and CAA as the targets per quarter were increased 2 to 3 times for all the indicators, based on the revised and reduced programme duration. CHAHA team emerged successful and met this challenge without any dilution of the quality of services which meant understanding each child and meeting his or her specific needs. During the Year 3, the challenge was not achieving the targets, as they were similar to those in the latter part of Year 2, nor was it further strengthening of the quality but it was to start planning for sustainability, as the programme has funding for just three more quarters. CHAHA has emerged successful yet again, but there is a growing recognition at every level that much more needs to be done to see that CLHIV and CAA are not forgotten or left uncared for.

Successes beyond the target have been on many fronts during the year. Midterm evaluation and evaluation using the most significant technique indicated a positive impact of the programme, which raised the commitment levels among all partners and helped to step up advocacy measures. The linkages and referrals for welfare schemes and services have been effective and have supplemented CHAHA’s support to the beneficiaries. Issues of CLHIV and CAA have become national priority. Alliance India has played a vital role in the Early Infant Diagnosis programme and there have been significant outcomes of advocacy related to cotrimoxazole prophylaxis and double ration for CLHIV and CAA.

The response from the government departments has increased, as has been the number of beneficiaries accessing various government welfare schemes and health services. The twin concerns of sustainability of the benefits that have accrued and will accrue from the project, and the need to expand these efforts countrywide will however continue to drive the programme partners to greater efforts during the remaining 200 days of this project. Experience of Alliance India has shown that programmes
such as CHAHA build bridges between those in need of services and government schemes and entitlements. They not only increase people’s capacities to demand services but also increase the capacities of service providers to provide them as per the need.

Analysis of the family status of the children enrolled in CHAHA strongly argues in favour of a continuing need for home and community based care and support programmes. For example, 21% of CLHIV are currently orphans and the need to provide them with care and support will continue. About 43% CLHIV have only one parent alive, and there is a real possibility of many of them becoming orphans and thereby requiring additional care and support (Figure 8). The programme purposively enrols those most in need and special programmes for CLHIV and CAA will be a continuing need as long as the epidemic continues to impact large numbers.

With the growing success of PPTCT programme, the number of new CLHIV is expected to decrease. The effective roll out of the ART programme and sharp reduction in number of children born positive to PLHIV women and the fact that the PLHIV can now look forward to a longer productive life may encourage an increased number of positive women to satisfy their maternal urges and choose to have children. This would mean an increased number of CAA. The programme partners believe the need for child-centric care and support programmes will remain.

**Operations research**

Two operational research (OR) studies were undertaken during the year on exploring the specific challenges and barriers related to HIV testing and disclosure and on ensuring sustainable access for children and their families to ART centres. The OR on HIV testing and disclosure was conducted in Andhra Pradesh and Manipur whereas barriers for sustainable access to ART were studied in Maharashtra and Manipur. The studies used qualitative and quantitative methods.

**Facilitating HIV testing and disclosure with children and adolescents**

CHAHA programme had adopted child friendly counselling approaches but was not following any specific disclosure guidelines. An operational was conducted to identify challenges and factors that prevented the community from seeking HIV testing for their children and to understand issues related to disclosure of HIV status to children including the psychological issues and social impact related to disclosure that the parents faced by parents and children. Findings of this study were mean to support CHAHA in formulating practical solutions to address issues related to testing and disclosure in short to medium term and to recommend ways to build synergistic linkages between policy and practice. The study identified the following key factors preventing HIV testing:

- **Fear of Stigma and discrimination** that intensifies with reports of discrimination within the families and communities
- **Financial constraints**, which increase the fears about loss of wages, high travel costs to testing centres and the probability of high financial burden on the family
- **Fear of disclosure within the neighbourhood** in case of breach of confidentiality and the subsequent negative impacts were high especially among parents of children 0-6 years old

![Figure 8: Family status of children enrolled in CHAHA](image-url)
• **Inadequate knowledge about HIV and AIDS,** which made it difficult for parents of children 7-14 years to explain the importance of, and consequences of the HIV test result. Lack of awareness and sensitivity among healthcare providers were additional deterrees

• **Low motivation level** due to parents' inability to deal with grief and shock associated with their own positive status, fear of children testing positive, and disillusionment with the ART treatment's inability to cure the infection

• **Attitudes of the healthcare providers** such as unfriendly hospital environment and procedures, breach of confidentiality, high caseload on the service providers and lack of specialised training for counsellors.

The issues related to disclosure included:

• **Challenges and dilemmas,** that emanate from the parents or caregivers’ belief that children 0-6 years were too young to comprehend the consequences of HIV status and their own guilt and mental turmoil. Often they were unable to decide whether to disclose or not and the right age for disclosure. They were also unsure of their ability to deal with issues that may emerge after disclosure and lack of guidance and counselling support from ICTC on disclosure

• **Channels of disclosure,** which in order of preference wase parents, NGO staff and ICTC staff. Most parents opined that they were best placed to assess the most opportune time for disclosure, psychological status and temperament of their children. NGO staff evoked high degrees of trust and were therefore looked up to for support. Inadequate post-test counselling, especially about disclosure, made a significant difference in the way children learned about their own status and/or their parents’ HIV status. The fears and concerns were highest when the children learned of the HIV status either through overhearing or suspicion

• **Immediate psychosocial effects of disclosure** were pain, fear, worry and helplessness. The children experienced pain about their parent’s health, limited ability to earn and the need to take up economic activity. The fears largely arose with the parents’ warning to keep the HIV status confidential for the fear of hostility from the community. The children tended to worry about financial insecurity, sustainability after parents’ loss, loss of rented accommodation or reduced matrimonial prospects, especially for girls. The helplessness was largely associated with the parents’ health condition and life after their demise, taking up family responsibilities and discontinuation of education to earn a livelihood.

The key recommendations were to:

• **Modify healthcare service delivery** by expanding number of testing centres and days of functioning, filling gaps in resources and feasible and flexible timings for testing centres, and strengthening monitoring of ICTC staff

• **Improve diagnostic services for children below 18 months** by creating awareness about and demand for early infant diagnostic procedures such as DNA-PCR and Dried Blood Sample method

• **Address stigma and discrimination** by sensitising service providers, involving children and families in programme and policy framework, enhancing role of community leaders and strengthening support groups

• **Establish improved and focused counselling services** by using services of professionally skilled counsellors and reallocating budget proportionate to their qualifications and experience, and using child-centred counselling techniques, scaling up of youth friendly testing and counselling facilities, developing systematic plans to assist parents in disclosure and promoting positive living

• **Strengthen capacity building and training** for parents, healthcare providers and NGO staff by developing appropriate training tools with practical guidance notes on disclosure to children. Priority was for training counsellors in child-centric counselling and health care providers in dealing with young adolescents, especially young girls
• Strengthen information, education and communication (IEC) coverage by wide dissemination of IEC material and increasing awareness about the benefits of using IEC among children and their families.

Barriers to sustainable access of children and families to ART centres in rural India

One of the prime objectives of CHAHA is to improve access to health care and medical services and therefore prevention, treatment, care and support continue to be the focus of CHAHA’s intervention process. Access to ART has been facilitated by financial support to families by covering the travel cost of taking the child to ART centre, facilitating and monitoring treatment follow-up and providing paediatric counselling, nutrition and medicines such as cotrimoxazole prophylaxis.

The operational research, which employed both qualitative and quantitative methods involving community survey, stakeholders’ interviews and facility survey, identified the following barriers to sustainable access of children and families to ART centres:

- **Stigma and discrimination** at various levels such as family, community, educational institutions and healthcare facilities
- **Economic constraints** due to inadequate resources in poor and child-headed families
- **Infrastructural issues** such as location of ART centres at distant locations, non-availability of transport and travel time and insufficient ART centres to cater to a large number of clients
- **Unsatisfactory support from parents and caregivers** due to long procedures at ART centres and costs involved in reaching ART centre
- **Lack of awareness about paediatric ART services**, which are mainly due to lack of child focussed IEC on HIV and AIDS including paediatric ART, treatment options and benefits and issues related to adherence
- **Lack of adequate capacity and accountability of ART centres**, which were mainly due to inefficient administrative procedures, non-availability of professionals skilled in paediatric ART, inadequate paediatric counselling and widespread locations for the processes from registration to treatment
- **Lack of coordination, collaboration and convergence** between related agencies, departments and programmes such as ICDC, reproductive and child health (RCH), tuberculosis (Tb), PPTCT, HIV and paediatric ART.

The key recommendations were to:

**Deepen communication and decentralised response to address stigma and discrimination** by designing and implementing child focussed IEC through an appropriate mix of media, disseminating information on paediatric diagnosis and ART and involving a wide range of community groups and influencers.
Ease the infrastructural bottlenecks by decentralising ART services, increasing number of ART centres with services such as ICTC and CD4 count and establishing new Link Centres where new ART centres cannot be set up. To avoid waiting in long queues at different counters, it is desirable to set up direct referral of children from counselling and testing centres to ART centres, flexible timings and vernacular signage with pictorial depiction of various services.

Coordinate and converge for improved diagnostic and treatment services by coordinating between State AIDS Control Societies (SACS) and district health departments. National guidelines, training manuals and standard operating procedures on early infant diagnosis (EID) and exposed baby care (EVC) were desirable. It was imperative to integrate PPTCT and paediatric ART services with EID and follow-up. Free EID facilities needed to be set up at district level and options for providing ART with Directly Observed Treatment Short Course (DOTS) needed to be explored.

Augment capacity and responsiveness at ART centres by strengthening operational facilities, and provide a comprehensive package of services that includes counselling, HIV testing, PPTCT, ART and follow-up. Regular refresher trainings need to be conducted for all levels of staff. It was also important to enhance capacities of gynaecologists in government and private sectors and to develop uniform treatment protocols.

Learning from the children

Alliance India had adopted “Most Significant Change” technique to evaluate the programme by listening to the stories told by children on what HIV meant to them. The children had not only talked about anger, fear and rejection but also about defiance, affection and hope. Four domains of change were chosen for the study to encompass the four service delivery areas of the programme:

1. Change in quality of people’s lives
2. Change in levels of people’s participation
3. Negative changes because of the programme, and
4. Changes in staff capacity

Change in quality of life: Children and their caregivers had developed positive attitude and self-confidence. There was improved well being in terms of better health, increased socialisation and savings. It was a relief for many children and caregivers to overcome feelings of hopelessness and be able to interact with others. The children indicated high levels of confidence gained through support of CHAHA team and increased quality of life through greater confidence built through training, children support groups and counselling. The children had also been able to

| Jamuan Devi, a 25-year-old mother of three children, from Manipur broke down when she said, “Earlier I did not want to live. After meeting CHAHA team, I do not want to die. The curry exchange (exchanging food) with my neighbours is going on and the neighbours do not look down upon me. People die irrespective of whether they have an illness or not, and so I do not think too much about my illness. The only thing that burns like fire in my heart is the thought of my child having HIV infection.” |
| DESIRE TO LIVE |

| “Our old relatives and friends did not respect us, so I did not want to go and relate to them again. The new relations understand my situation and relate to me. My old relations treated me badly but the new relations comfort me. Also they take care of my brother which makes me happy.” |
| OLD IS NOT ALWAYS GOLD |

- C Sathya, student of Class 8
develop positive attitudes about their parents’ HIV status.

**Level of participation:** Children and caregivers had been able to disclose their status, interact with people and overcome feelings of being stigmatised by the communities. Many children had begun to spread messages on prevention, treatment and care without any extrinsic push. Support to the family and nutritional and educational support for the children had increased the children’s capacities to cope, which in turn had increased the levels of participation.

**Negative change:** Many children feared disclosure of their HIV status because of frequent visits of outreach workers to their house. There was also displeasure with promises that were not kept, especially promises of certain services, which were not received by the children. The stories also highlighted multiple burdens being borne by women and the deep pain felt by the children for such mothers. The orphans particularly felt hopeless at the thought of inability to receive continued care by elderly caregivers.

**Changes in staff capacity:** The stories indicated a deep level of commitment and tremendous contributions made by the outreach workers. The stories reflected a great sense of pride felt by the staff, many of who reported changes at a personal level such as being able to control anger, internalising values of child participation and applying them to their own children. Such personal changes also had a direct impact on their work. The project coordinators and assistant project coordinators had expressed an increase in level of several skills such as interpersonal communication, networking, knowledge of HIV and AIDS and enhanced programme management.

The improvement in quality of people’s lives was greater when CHAHA was implemented in conjunction with other programmes of the SSR. For example, CARE, one of the SSR in Tamil Nadu had integrated CHAHA with its longer-term programmes on women’s empowerment, livelihood and micro finance.

**Building linkages and referrals**

One of the primary components of CHAHA programme is to link families with government schemes that can reduce the adverse impact of HIV and AIDS. Strengthening the linkages between the community and the government schemes was an effective way to allow CHAHA to withdraw direct services without any significant loss to the beneficiaries. In other words, this was strategy for sustaining the benefits accrued to beyond the programme. In order to assess the effectiveness and adequacy of the linkages, Alliance India had undertaken an operational research on referral linkages with government scheme under the CHAHA programme.
Currently, there is no government or NGO scheme that can replace the emergency support provided by CHAHA programme.

Methodology

The study was an exploratory and qualitative study with primary and data collection from key stakeholders including government and private service providers, social networks, community and beneficiaries. It was carried out in two districts in each of the four states covered under the CHAHA programme. Two focussed group discussions (FGDs) were conducted in each district—one with parents and caregivers and another with CLHIV and CAA – to assess gaps in service delivery, linkages, issues of sustainability and advocacy and cross cutting issues. FGDs were also conducted with self-help groups (SHGs) and community based organisations (CBOs) to identify issues of inclusion in economic empowerment, income generation programmes and their adequacy, and effectiveness in the CHAHA programme. It also involved review of documentation of links to ART and PPTCT centres, ICTC and ICDS maintained by the SSR.

Key findings and recommendations

All the beneficiaries and stakeholders reached during the study had appreciated the CHAHA programme, especially the direct support, which may be difficult to provide through other programmes and schemes. There were significant regional variations within and among the states in terms of linkages. This highlighted the crucial question of sustainability once the programme support was withdrawn. One of the key concerns is also the difficulty in substituting CHAHA strategies with large government schemes as the former’s success is based on whetting the needs of each beneficiary and providing focussed, flexible and comprehensive support.

Nutritional support: CHAHA programme allows nutritional support to 20% of the children registered. The SSRs had established effective linkages with existing government programmes and linked the CLHIV and CAA to:

- ICDS, for providing special nutrition to children 0-6 years of age
- The public distribution system (PDS), for providing cereals, sugar, kerosene, etc. at subsidised rates, and
- Mid-day meal scheme that covers all children studying in government schools

Emergency household support: The household support was provided based on community assessment done by each SSR and therefore varied between various states and districts. The beneficiaries were very appreciative of the support, which included, among others, financing travel to hospital and medical expenses, clothes, construction of toilets, repairs of the house, or purchasing household goods such as electrical fans, reading table and chair, utensils, water filters, cost of funeral, etc.

Income generation support: Stigma and discrimination often compels PLHIV to withdraw from economical gainful activities even if they are healthy. Other family members may suffer loss of income when PLHIV require special care. The additional burden of medical expenses and nutritious foods further depletes the economic status of the affected families. Several parents and caregivers of CLHIV and CAA had registered with the National Rural Employment Guarantee Act (NREGA), which guarantees 100 days of employment in a year to people in the rural

“Working the fields may be more profitable but it would mean neglecting my children. With the support from NGO, I have set up this petty shop in my own home, which allows me to take care of children and earn at the same time”

– A beneficiary in Theni district, Tamil Nadu
areas. Information on mothers and other women caregivers of CLHIV and CAA benefitting from microfinance through SHGs was not available. A large number of the beneficiaries were not aware of other income generation schemes such as Jawahar Rozgar Yojana. Accessing these schemes involves procedural requirements and fulfilling their eligibility criteria. However, those able to go out for employment can benefit from such schemes.

Despite being linked to income generation programmes of the government, the beneficiaries were more appreciative of CHAHA initiatives as the programme not only provided funds but also technical assistance and garnered community support. It was evident that merely providing cash support had limited benefit unless it also involved skill development and training in marketing.

**Education support:** CHAHA has supported education of CLHIV and CAA by paying school fees, tuition fees, uniforms, books, bus passes, etc. The 86th Amendment to the Constitution of India makes provision of free and compulsory education to children 6-14 years a Fundamental Right. There is therefore immense potential to link the children to the government’s flagship programme – Sarva Shiksha Abhiyan (SSA), which focuses on universalisation of elementary education in a time bound manner, is being implemented in partnerships with the state governments. CLHIV are covered under the SSA although no special privileges have been offered to them.

**Access to health care:** All the SSRs had established effective linkages with various government health facilities such as primary health centres, ICTC, PPTCT centres, ART centres and Community Care Centres (CCCs). The SSR in Maharashtra have also linked the beneficiaries to several government schemes such as Jeevandaayi Yojana, Matruta Anudan Yojana, Janani Suraksha Yojana and Savitri Bai Phule Yojana for the overall welfare of PLHIV even though these schemes do not have specific provisions for PLHIV.

**Psychological support:** ICTCs and ART centres have trained counsellors who can provide psychological support related to disclosure, family issues and ART. Counselling CLHIV and CAA requires addressing many more issues, which has not received adequate attention in the national programmes. CHAHA staff have been adept at creating a supportive environment for CLHIV and CAA through child support groups, which has had an impressive impact on the children. Currently, there are no government schemes for providing continuous psychological support to the children although states such as Tamil Nadu are trying to establish structures to respond to such needs.

**Advocacy**

Advocacy and policy work is an integral part of Alliance India’s work. During the current year, Alliance India developed an advocacy strategy focussing on better implementation of Children and AIDS Policy Framework developed by NACO and the Ministry of Women and Child Development (MWCD), which aims to provide comprehensive care and support services to CLHIV and CAA. The main objective of the advocacy was to consistently negotiate and lobby with the government departments to implement the policy, and to ensure that the end
users have access to the services by the end of 2010. Two themes based on this family were identified for the advocacy:

- Providing supplementary nutrition to CLHIV up to 14 years Integrated Child Development Services (ICDS) Scheme and Mid-Day Meal scheme, and
- Providing cotrimoxazole prophylaxis (CTX) to all children below five years born to mothers living with HIV until it is established that children are HIV negative.

Alliance India had selected the above two themes for advocacy based on field reports and observations during the field visits. Interactions with the service providers in the programme areas had also highlighted these themes are important services for CLHIV.

**Supplementary nutrition**

The importance of adequate and appropriate nutrition for CLHIV and CAA is undisputed. Children born to mothers living with HIV are more likely to have low birth weight. CLHIV need extra nutrition to gain weight and counter common infections, and the need increases when they are on ART. CAA are also more likely to have poor nutritional status as compared to children born to HIV negative parents. The current child centric programmes, however, are not designed to meet all the nutritional requirements of CLHIV and CAA. For example, through CHAHA, Alliance India can provide nutrition to only 20% of the children and the programme has had to provide this facility selectively to those most in need. This is why it was imperative to work with government systems and facilitate linkages with ICDS schemes and government schools with Mid-day Meals.

The Directorate of Women and Child Welfare Department (DWCD) of Andhra Pradesh had issued an Office Order in April 2008 to provide double ration to CLHIV and CAA in the age group of 0-6 years through ICDS programme. This landmark decision by the DWCD was the result of Advocacy efforts of CHAHA and Balasahayoga, another care and support programme implemented by Family Health International (FHI) and its partners. They had gathered evidence on the need for additional nutrition for CLHIV and CAA and presented them to the Project Director, Andhra Pradesh State AIDS Control Society, who in turn liaised with the DWCD. The double ration scheme is being implemented in all the districts of Andhra Pradesh where CHAHA programme has enrolled children. Distinctive strategies have been adopted by SR at state level and SSR at district levels to ensure successful follow-up of the Office Order.

A series of sensitisation meetings with concerned state and district officials of the department of women and child development were held. List of CLHIV and CAA below 6 years were shared with the Child Development Project Officers (CDPOs). Details of the order were shared with the supervisors and anganwadi workers (AWWs). CHAHA SSRs also worked towards effective collaboration with ICDS by attending the monthly meetings of department of women and child development at district and sector levels. Barriers for issuing double ration to CLHIV and CAA were addressed jointly by CHAHA team and the ICDS functionaries. For example, shortage of supply was resolved by utilising surplus ration allocated for children with Grades II and III malnutrition.

The ORWs discussed about the double ration provision during all community meetings and home visits. The eligible children were linked to anganwadis, who began recording the children’s supplementary nutrition intake and growth monitoring in their regular register, or in some cases, in a special register. None of the registers however indicate the HIV status of the children. Periodic feedback from the beneficiaries has helped the ORWs address their issues and concerns such as the quality of food provided at anganwadis. The ORWs and AWWs did regular nutrition demonstration to enhance the mothers and caregivers’ knowledge about low cost nutritious foods and healthy cooking practices.
One of the major outcomes of the Advocacy on supplementary has been a decision taken by the Directorate of Women and Child Development, Government of Andhra Pradesh, to provide double nutrition (double of the allocation for each child) to CLHIV and CAA 0-6 years old through the anganwadi centres.

Cotrimoxazole prophylaxis

NNACO estimates of 2007 indicate that about 70,000 children below 15 years of age are living with HIV and 21,000 children acquire the infection through mother to child transmission every year, most of who are estimated to die before five years of age. Pneumocystis Jiroveci Pneumonia (PCP) has been identified as the leading cause of death among infants living with HIV. Current infrastructure makes it difficult to diagnose HIV infection among infants and therefore cotrimoxazole prophylaxis is recommended for all infants born to women living with HIV to receive cotrimoxazole prophylaxis starting from 4-6 weeks of age till HIV infection is excluded. This is considered to be a simple, well-tolerated and cost effective intervention for CLHIV. Although NACO has trained the ART medical officers on CTX prophylaxis, the number of infants born to mothers living with HIV availing this service is low.

CHAHA had conducted a situational assessment in its implementation areas to understand the issues related to CTX prophylaxis for infants exposed to HIV. Key findings of this assessment were a hesitation amongst healthcare providers to provide CTX prophylaxis because of the fear of contraindications or side effects and issues related to regular supply of the drugs. Alliance India therefore took a decision to advocate with healthcare providers on benefits of CTX prophylaxis and to work consistently with NACO to support the advocacy work.

Activities related to advocacy on supplementary nutrition and CTX prophylaxis includes much closer coordination between ART and ICDS programme and NRHM at various levels. It also seeks to develop appropriate IEC material on CTX prophylaxis and supplementary nutrition and to use special events like International Women’s Day, Global AIDS Week of Action
There were several challenges related to advocacy for CTX prophylaxis at field level. Convincing healthcare providers on the benefits of such prophylaxis was time intensive as they lacked clarity on paediatric ART guidelines and the programme partners lacked confidence to deal with the technical issues. Regular meetings with the healthcare providers and monitoring and technical support visits to the partners had helped address these challenges. Alliance India had also developed IEC material on CTX prophylaxis in consultation with NACO, which were effective in enhancing confidence of the healthcare providers and implementing partners. Sharing analysis of data from the implementing partners during the various meetings and special events were also helpful in addressing the barriers.

The SSR have also been educating the community on CTX prophylaxis and special supplementary nutrition provisions for CLHIV and CAA in order to generate demand for services. The outreach workers, volunteers and counsellors of CHAHA programme have also been trained on the issues to strengthen their abilities to educate the community. Special emphasis was given to education of the pregnant women on CTX prophylaxis.

**Synergy with existing programmes**

The Tamil Nadu State AIDS Control Society (TNSACS) has set up a Tamil Nadu Trust for Children Affected by AIDS (TNTCAA) to serve the orphans and vulnerable children (OVC) in the state. A Memorandum of Understanding (MOU) has been signed for a year between the TNTCAA and Alliance India to use the CHAHA outreach team for verification of the applications received by TNTCAA from the CHAHA areas.

TNTCAA provides financial assistance to facilitate a continuum of services to ensure a holistic supportive environment to CLHIV and CAA aged 5-18 years and ensure that the children remain within the families and the community settings.
as far as possible. The support will be given to the children, their families and care givers for education (including vocational training), nutrition, shelter, legal services and medical care. The benefits of the Trust are open to all children who are socially and economically disadvantaged CLHIV and CAA irrespective of their caste, religion, gender or class.

The MOU requires Alliance India and its partners to help CLHIV and CAA in CHAHA areas who are unable to get the benefits under the programme because of the upper limit of children it can register to access the services of the Trust. This also ensures that duplication of services for the same children are avoided and services to OVC in Tamil Nadu are scaled up to cover all CLHIV and CAA.

Early infant diagnosis

In recent years, there has been a major expansion of HIV related services including PPTCT, ICTC and ART services for adults and children, and access to early diagnosis for HIV testing of infants and children below eighteen months of age. NACO’s draft guidelines recommend anti-retroviral prophylaxis within 72 hours of birth, cotrimoxazole prophylaxis from six weeks until HIV infection is reliably excluded and HIV testing of the child through HIV DNA PCR or antibody testing depending on the age of the infant or child. It also recommends regular follow-up, immunisation as per national schedule, nutritional counselling for parents and caregivers and ART and other treatment as necessary.

Operationalization of the EID guidelines for HIV exposed infants and children below eighteen months requires strong linkages and referrals from the various health facilities from districts and sub districts to specialised services such as ICTC, ART centres and Paediatric departments. Alliance India partners will mobilise the communities to take their children for DNA PCR testing to ICTCs where EID facilities are available. NACO shared the list of ICTCs with Alliance India, which in turn shared it with SRs and SSRs to establish linkages with
the ICTCs. SRs and SSRs were also trained on EID guidelines and the importance of early diagnosis for HIV exposed children. NACO also informed SACS in four CHAHA states about Alliance India’s role in supporting EID roll out, which resulted in enhanced support from SACS. To increase access to EID, the SSR had organised meetings with various stakeholders and the community during the Global AIDS Week of Action (GAWA) to:

- Sensitise the ICTC counsellors, community volunteers and caregivers about EID

- Make available facilities under NACO’s national essential package of care for HIV exposed infants and children less than 18 months, and

- Motivate mothers and caregivers for DNA PCR test for early detection of HIV among children 6 weeks to 18 months of age at the ICTCs wherever facilities were available.

Community level meetings were held with women having children under 18 months of age, pregnant women and positive women whose children had not been tested. Issues discussed during the meetings included need for early testing, guidelines for EID and cotrimoxazole prophylaxis. Information on ICT centres where EID facilities were available was also shared during the meeting. These meetings had helped motivate mothers of infants and children 6 weeks to 18 months to seek EID services. A list of children eligible for EID in each implementation area was shared with District AIDS Prevention Control Unit (DAPCU) and a plan was formulated for testing. The outreach workers accompanied the parents and caregivers for testing.

A special emphasis on EID during the GAWA had helped sensitise the ICTC counsellors and other service providers and motivate a large number of parents and caregivers to get children 6 weeks to 18 months get tested for HIV. During the week, 300 children were mobilised through CHAHA programme, of which 115 were tested and the results were awaited. CHAHA partners are following up with the service providers to get the results and get the tests done for remaining children. The EID was not rolled out in Manipur due to logistical problems and NACO is making efforts to start the roll out soon.
Lessons Learned

There were several lessons learned from CHAHA programme, especially through feedback from the community, SSR and SR, service providers and other stakeholders, findings of the operational research and review of programme documents.

a. Need for systems to provide emergency support: It is important to give priority to short term, immediate needs as perceived by children and their caregivers. For example, young widows may feel the need for safe shelter for themselves and their children, children headed households may require shelter and financial assistance to seek treatment, etc. Unless these immediate needs are met, it is difficult to engage the children and their caregivers for a dialogue on long-term support and health seeking behaviour. The current social welfare systems of the government and HIV programmes are not designed for a rapid response for emergencies.

Children headed households, children living with grandparents or with widowed mother coping alone are especially vulnerable to the adverse social, economic and health impacts of HIV. Among the beneficiaries of CHAHA programme, 35% of the households are headed by women and 8% by orphaned children. Widows often experience higher levels of stigma, which dissuades them from working or accessing services. The outreach workers of CHAHA have learned offering immediate assistance to address emergencies normally leads to a long-term relationship, which in turn helps them address issues of testing, disclosure and adherence. Such individuals are among those most in need and are in need of services that focussed programmes designed by the government for the entire community are unable to provide.

b. Need for wider response to eliminate stigma and discrimination: Despite significant reduction of stigma and discrimination in the last decade or so, stigma and discrimination continue to be one of major deterrents for testing, disclosure and accessing services such as ART even when beneficiaries are aware of the services. Creating a stigma and discrimination free environment requires a proactive campaign to sensitisce of communities, their leaders and service providers, which health systems alone cannot manage. A wider response involving multiple sectors and stakeholders is therefore called for.

Stigma is not just external. Children and their families coping with HIV and AIDS experience significant self-stigma, which
makes children, withdraw from most social interactions. They feel that other children may not like their company and as such keep aloof furthering their isolation and making it difficult to make friends, attend schools or seek support and other services. This situation can be addressed only by seeking out children and spending time with them and providing them with the needed support rather than waiting for them to approach service providers.

c. Need to focus on welfare of the entire family: There is a close inter-relationship between a child’s welfare and the welfare of the family, including siblings. Families of children infected and affected by HIV live with considerable stress due to factors ranging from loss of parent and wage earner to stigma associated with HIV. It is difficult to such families to have confidence to test the child, disclose the status, care for the child and ensure sufficient nutrition. It is therefore essential to ensure psychological well being and economic stability of the family in which the child lives.

A child centric programme needs to look beyond the needs of the child and help the household in which the child lives in order to develop a sustainable environment where the child’s health and social needs are met.

d. Need to address sexual and reproductive health issues: A large number of children enrolled into CHAHA programme are above 13 years of age and therefore can benefit from sex and sexuality related education and support. Moreover, increased access to ART has made it easier for young PLHIV to live longer, healthier lives. Many of them prefer to be sexually active, while many others may be vulnerable to sexual exploitation. They also have questions, fears and concerns related to sexual and reproductive health (SRH), which the current child centric programme does not address. Making sex and sexuality education an integral part of life skills education and establishing linkages with SRH related services can go a long way in filling this gap.

e. Need for detailed documentation: Detailed documentation helps effective planning for utilisation of various government schemes and services. It also provides credible evidence to help the government take steps towards meeting critical needs of the children. Types of documentation include, among others, detailed mapping of CLHIV and CAA and their parents and caregivers, individual child records giving details such as growth monitoring, nutritional supplementation, immunisation, HIV status, registration at ART centres and adherence if on ART, CTX prophylaxis (where applicable), school enrolment and attendance at school, family entitlements, etc.

f. Need for periodic feedback from the community and various stakeholders: Periodic feedback from the community on the services helps ensure sustained quality of services and thereby develop a trusting environment. Hearing children’s voices and feedback from the community has helped the CHAHA team become more responsive and to design initiatives that meet the felt needs of the children and their families. Feedback from the stakeholders helps modify programme design to make it more effective and help develop realistic expectations of the community.

g. Need for linkages: Developing linkages and building rapport with service providers at every level helps sensitise them to the special issues related to CLHIV and CAA promotes overall childhood development, prolongs life and improves health of the parents and children and gives CLHIV, CAA and their families greater confidence to become an integral part of the society. Linkages also help prepare basic documents such as ration card, birth and death certificates, etc. that are essential for benefitting from government schemes such as widow pension, housing schemes, loans for income generation etc.
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.

The members of Alliance India are 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.
The CHAHA programme entered the Phase 2 in April 2009. However, since the programme started in June 2007, the annual report follows a reporting period from July to June. The report for Year 3 is for the period July 2009 to June 2010. The Income received during the year 3 of the project is US$4.45 million.

Expenditure at the end of year 3 has reached more than US$4.02 million, of which onward grants to Sub-recipients is 81% during the year.

The funding has helped us to expand our programme coverage of reaching 49,040 children infected and affected by HIV and their families.
Alliance India’s CHAHA Partners

Andhra Pradesh

Sub Recipient: LEPRO Society
Sub-Sub Recipients
• GRAM Abhyudaya Mandali
• Peoples Action for Creative Education
• Hyderabad Leprosy Control and Health Society
• Divya Disha
• Ravicherla Integrated Development and Educational society
• Women’s Organisation for Rural Development

Sub Recipient: Vasavya Mahila Mandali (VMM)
Sub-Sub Recipients
• Deepthi Socio Educational Society
• Gramasiri Rural Activities in National Development Society
• Youth Club of Bejjipuram
• Green Vision

Sub Recipient: Plan India
Sub-Sub Recipients
• Arthik Samata Mandal
• Janakalyan Welfare Society
• Rural Energy for Environment Development Society
• GUIDE
• Society for Help Entire Lower & Rural People
• Social Activities for Rural Development Society
• Chaitany Jyothi Welfare Society

Sub Recipient: Alliance for AIDS Action
Sub-Sub Recipients
• Dedicated People’s Union (DPU)
• Sneha Bhavan- Imphal East
• Sneha Bhavan-Chandel
• Sneha Bhavan – Thoubal

Manipur

Sub Recipient: Social Awareness Service Organisation
Sub-Sub Recipients
• Social Awareness Service Organisation
• Manipur Network of Positive People (MNP+)

1Replaced by Grama Swarajya Samithi w.e.f. 1st May 2010
2Replaced by Ravicherla Integrated Development and Educational society w.e.f 15th June 2010
3Alliance India has assumed the responsibility of SR in place of Alliance for AIDS Action beginning February 2010 through its Hyderabad office
Maharashtra

Sub Recipient: MAMTA-HIMC
Sub-Sub Recipients
- Bharatiya Adim Jati Sevak Sangh
- RTM SAP Mandal
- Janhitay Mandal
- Kripa Foundation
- Jeevan Vikas Sanstha
- Nagpur Multipurpose Social Service Society

Sub Recipient: Plan India
Sub-Sub Recipients
- Committed Communities Development Trust
- Community Aid & Sponsorship Programme (CASP)

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

Tamil Nadu

Sub Recipient: Palmyrah Workers Development Society (PWDS)
Sub-Sub Recipients
- 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)

Sub Recipient: Tamil Nadu Social Service Society (TASOSS)
Sub-Sub Recipients
- Society for Serving Humanity (SSH)
- Village Reconstruction and Development Project (VRDP)
- Women’s Organization in Rural Development (WORD)

Sub Recipient: Tamil Nadu Social Service Society (TASOSS)
Sub-Sub Recipients
- 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)