Headquartered in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national programme, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations affected by the epidemic. The organisation’s programmes focus on those most vulnerable to HIV, with a particular emphasis on marginalised populations including men who have sex with men (MSM), transgenders, hijras, sex workers, injection drug users (IDUs), at risk youth and women, and people living with HIV (PLHIV).

Published: June 2014
© India HIV/AIDS Alliance

Information contained in the publication may be freely reproduced, published or otherwise used for non-profit purposes without permission from India HIV/AIDS Alliance. Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV status.

Images © Prashant Panjiar and Peter Caton for India HIV/AIDS Alliance

Design: Sunil Butola, India HIV/AIDS Alliance

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>ii</td>
</tr>
<tr>
<td>Foreword</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>v</td>
</tr>
<tr>
<td>1 Stepping In: Pre-Avahan</td>
<td>1</td>
</tr>
<tr>
<td>2 Overview of Avahan</td>
<td>11</td>
</tr>
<tr>
<td>3 Outreach Services</td>
<td>23</td>
</tr>
<tr>
<td>4 Clinical Services</td>
<td>33</td>
</tr>
<tr>
<td>5 Community Mobilisation and Advocacy</td>
<td>53</td>
</tr>
<tr>
<td>6 Monitoring &amp; Evaluation</td>
<td>73</td>
</tr>
<tr>
<td>7 Transition of Avahan</td>
<td>83</td>
</tr>
<tr>
<td>8 Studies, Manuals, and IEC Material</td>
<td>91</td>
</tr>
<tr>
<td>9 Challenges and Key Learnings</td>
<td>99</td>
</tr>
<tr>
<td>10 Achievements of Avahan</td>
<td>105</td>
</tr>
<tr>
<td>Our Avahan Team</td>
<td>108</td>
</tr>
</tbody>
</table>
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>APSACS</td>
<td>Andhra Pradesh State AIDS Control Society</td>
</tr>
<tr>
<td>APC</td>
<td>Assistant Project Coordinator</td>
</tr>
<tr>
<td>AV</td>
<td>Audiovisual</td>
</tr>
<tr>
<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
</tr>
<tr>
<td>BTS</td>
<td>Behaviour Tracking Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>CMIS</td>
<td>Computerised Monitoring Information System</td>
</tr>
<tr>
<td>CMP</td>
<td>Common Minimum Programme</td>
</tr>
<tr>
<td>COGS</td>
<td>Clinic Operating Guidelines and Standards</td>
</tr>
<tr>
<td>CQMT</td>
<td>Clinic Quality Monitoring Tool</td>
</tr>
<tr>
<td>CST</td>
<td>Care, Support and Treatment</td>
</tr>
<tr>
<td>CSRC</td>
<td>Clinic Service Review Committee</td>
</tr>
<tr>
<td>DAPCU</td>
<td>District AIDS Prevention &amp; Control Unit</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop-in-Center</td>
</tr>
<tr>
<td>DMHO</td>
<td>District Medical Health Officer</td>
</tr>
<tr>
<td>DMC</td>
<td>Designated Microscopic Centre</td>
</tr>
<tr>
<td>DMSC</td>
<td>Durbar Mahila Samanwaya Committee</td>
</tr>
<tr>
<td>DOTS</td>
<td>Direct Observed Treatment</td>
</tr>
<tr>
<td>DSRC</td>
<td>Designated STI RTI Clinics</td>
</tr>
<tr>
<td>DRDA</td>
<td>Department of Rural Development Agency</td>
</tr>
<tr>
<td>EQA</td>
<td>External Quality Assurance</td>
</tr>
<tr>
<td>ED</td>
<td>Executive Director</td>
</tr>
<tr>
<td>FPP</td>
<td>Frontiers Prevention Programme</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRG</td>
<td>High Risk Groups</td>
</tr>
<tr>
<td>HS</td>
<td>Hotspot</td>
</tr>
<tr>
<td>KP</td>
<td>Key Populations</td>
</tr>
<tr>
<td>IBBA</td>
<td>Integrated Behaviour and Biological Assessment</td>
</tr>
<tr>
<td>ICTC</td>
<td>Integrated Counselling and Testing Centre</td>
</tr>
<tr>
<td>ICST</td>
<td>Immuno Chromatography Strip Test</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
</tr>
<tr>
<td>NACO</td>
<td>National AIDS Control Organisation</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>ORW</td>
<td>Outreach Worker</td>
</tr>
<tr>
<td>PAC</td>
<td>Project Advisory Committee</td>
</tr>
<tr>
<td>PD</td>
<td>Project Director</td>
</tr>
<tr>
<td>PE</td>
<td>Peer Educator</td>
</tr>
<tr>
<td>PC</td>
<td>Project Coordinator</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Center</td>
</tr>
<tr>
<td>PM</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
</tr>
<tr>
<td>PSA</td>
<td>Participatory Site Assessment</td>
</tr>
<tr>
<td>PTS</td>
<td>Performance Tool</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td>RPR</td>
<td>Rapid Plasma Regain</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infections</td>
</tr>
<tr>
<td>SLP</td>
<td>State Lead Partner</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender</td>
</tr>
<tr>
<td>TI</td>
<td>Targeted Intervention</td>
</tr>
<tr>
<td>TS</td>
<td>Technical Support</td>
</tr>
<tr>
<td>TSS</td>
<td>Technical Support Staff</td>
</tr>
<tr>
<td>TSU</td>
<td>Technical Support Unit</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
</tbody>
</table>
Foreword

So much has been written about Avahan – by implementers, academics, and journalists – that to write more might be unnecessary. Many have reflected on the complexity of the programme and its ambition. What would it take to have an impact on the HIV epidemic in India’s highest burden states at a scale usually expected only of government? The learnings of Avahan are ample and thusly well documented. India’s fascination with Avahan’s donor surely was a story unto itself and told many times.

Yet, for me, the central contribution of Avahan is simple, and remarkably, it still remains radical today. Leveraging the prestige and resources of the Bill & Melinda Gates Foundation, Avahan focused its efforts on key populations, groups whose social marginalization previously all but ensured that their needs would not be adequately prioritized in spite of their disproportionate vulnerability to HIV.

Before Avahan arrived, India had already recognized that sex workers were an important driver of the country’s epidemic. The data told this story, and the government had a plan. Other key population groups like men who have sex with men and people who inject drugs were similarly targeted. Yet, capacity in the government to meet these challenges was limited. Apprehension about HIV was just part of the problem. How does a government effectively protect the health of groups that are criminalized and pushed to the margins of society?

What Avahan did – putting key populations first – should have been game-changing for the global AIDS response. How little the global AIDS response has actually changed now a decade later is testament to how difficult it is to break through the stigma and discrimination that define this disease. For all our talk in public health about evidence-based responses, what is done about AIDS still passes through a moral and political filter. Though we know we can find HIV concentrated in sex worker, MSM and drug-using populations worldwide, we still don’t invest resources to match the relative scale of the epidemic in these groups.

Avahan showed it can be done. The Bill & Melinda Gates Foundation deserves great praise for its vision and resolve. The Government of India’s National AIDS Control Organisation (now, Department of AIDS Control) and the State AIDS Control Societies were essential collaborators, giving the programme the space it needed to show an impact. The implementing partners in the six Avahan states across India, including Alliance India in Andhra Pradesh, had the learning journey of a lifetime. Our part of this remarkable story is documented in these pages.

James Robertson
Executive Director
India HIV/AIDS Alliance
Acknowledgments

This report, “Empowering Key Populations for Sustaining HIV Prevention: Avahan in Andhra Pradesh 2004-2014,” is a compilation of successes, challenges, and impact of Avahan, a targeted intervention programme, supported by the Bill and Melinda Gates Foundation and implemented for female sex workers, men who have sex with men, and transgender in 13 districts of Telangana and Rayalaseema regions of Andhra Pradesh (AP). The success achieved by the programme in the past ten years is a testimony to the commitment and passion of the community members and staff of NGOs and India HIV/AIDS Alliance (Alliance India) towards empowering key populations (KPs) to sustain the programme beyond 2014. The Avahan programme had undergone many changes during the journey, from service-centric to community-centric to community-driven program, with emphasis on transitioning the programme to the communities and its natural owners. Alliance India, with support from key partners, contributed to the overall success and positive impact of the Avahan programme on HIV prevention in AP.

This report would not have been possible without comprehensive, high quality, timely reports submitted by implementing NGOs/CBOs and an excellent CMIS system developed and managed by our M&E Staff. My sincere thanks to P Sriker, K Janardhan and R Ramakrishna for initiating, refining and managing M&E systems for the past 10 years. Thanks to Dr Saroj Tucker for undertaking the Herculean task of writing a comprehensive report of Avahan Phase I (2004-2009) and Phase II (2009-20014), including program strategies, achievements and impact. This report is a testimony of diligent and meticulous TI programme initiated in 2004 by the first regional Director of Alliance India, AP, Mr Shumon Sengupta.

I sincerely thank Mr James Robertson, Executive Director, India HIV/AIDS Alliance, for his encouragement and guidance throughout the implementation of the programme.

I would also like to thank Project Directors (former and current), Mr T Kailash Ditya, JD TI, Andhra Pradesh State AIDS Control Society, Hyderabad, and Mr K Jayakumar, Team Leader, TSU, HLF PPT for their support during the course of the Avahan programme.

I would like to extend special thanks to capacity building partners of Avahan: Population Council, FHI 360 M&E, STI (CB) Team, CFAR, PATH, Futures India, PRAXIS, and Dr Gina Dallabetta, Senior Program Officer, BMGF, Dr Theodora Wii, Medical Officer, WHO, WIPRO Office, and Dr Niranjan Saggurti, Program Associate, Population Council for their unstinting support to Avahan programme in AP.

This report would not have been possible without the financial support from the Bill and Melinda Gates Foundation (BMGF). I wholeheartedly thank Ms Matangi Jayaram, Senior Program Officer, for her encouragement in documenting successes, lessons learned and best practices of Alliance India’s Avahan programme.

Dr P Prabhakar
Director: Regional Office
India HIV/AIDS Alliance
Executive Summary

India HIV/AIDS Alliance (Alliance India) has been at the forefront of HIV prevention in India since 1999. To implement focused HIV prevention programmes in Rayalseema and Telengana regions of Andhra Pradesh (AP), Alliance India established a regional office in AP in November 2003. With support from the Bill and Melinda Gates Foundation (BMGF), Alliance India embarked upon a decade-long journey of HIV prevention with key populations (KPs) - female sex workers (FSW), men who have sex with men (MSM), transgenders (TG), injecting drug users (IDUs), and people living with HIV (PLHIV).

BMGF supported two programmes: Frontiers’ Prevention Programme (FPP), a multi-country initiative of International HIV/AIDS Alliance, UK; and Avahan–India AIDS Initiative, the largest focused HIV prevention programme of any country. The implementation of these two programmes overlapped: FPP was implemented between 2002 and 2008 and Avahan from December 2003 to July 2014. With the overall goal to bring down HIV and sexually transmitted infections (STI) incidence in the state, FPP and Avahan took slightly different approach and design to prevention efforts: FPP focused on empowering the community to take action to improve the situation whereas Avahan focused on the rapid roll-out of HIV prevention services. Alliance India combined these two approaches to implement a unique model that combined the community empowerment aspects of FPP with the structured service delivery of Avahan.

Avahan was implemented in two phases. The first phase (December 2003 to April 2009) concentrated on establishing systems to ensure maximum coverage of KPs with prevention services. The second phase (April 2009 to July 2014) focused on building capacity of non-governmental organisations (NGOs) and communities by increasing coordination with Andhra Pradesh State AIDS Control Society (APSACS) and the Technical Support Unit (TSU) for smooth implementation of the programme. Strategies included behaviour change communication (BCC), management of STIs, condom programming, creation of enabling environment, and KP mobilisation and empowerment. During the early years of implementation, Alliance India took specific approaches to implementation - Participatory site assessment (PSA), community participation and empowerment, clinic branding and colour-coded STI kits - that redefined the way Targeted Interventions (TI) were implemented in the country. Many of these approaches were later adopted by other state lead partners (SLPs) of Avahan and by the National AIDS Control Organisation (NACO).

Over the period of implementation of Avahan, Alliance India worked with 46 NGOs to reach out to over 75,000 KP members in 14 districts of AP. Within a period of six months in 2006, the programme was scaled up from 74 to 141 mandals, including those in the remotest and under-served areas of the regions. Additionally, about 6,000 PLHIV were provided services under the FPP. A total of 155 drop-in-centers (DICs) were set up to
provide a safe space for the community to relax and conduct group meetings. These DICs also served as places to provide STI services and were called Mythri Centers. A network of peer educators and outreach workers was created from within the community for the following: to create awareness among the KPs about HIV/STI; to promote condom use through distribution of free condoms, demonstration of the correct method of condom use, and building KPs’ negotiating skills for condom use; and mobilisation of KPs to attend STI clinics as well as group activities. In addition, a special pack of two Mythri condoms with two lubricants was prepared and outreach workers and community-based organisations (CBO) did social marketing of these packs and condoms.

Quality STI services were provided through 152 project-owned clinics (called Mythri Clinics), mobile clinics, and referral clinics. STI manual and protocol were prepared in 2004 to standardise the clinics and services. All Alliance India supported clinics provided additional services, such as treating general ailments and providing basic AIDS care to PLHIV. The Mythri Clinics were also a source of information and condom promotion, and a referral hub for treatment of complications or other medical problems. In September 2007, a Mythri Mainstreaming Model was developed wherein the STI services were also provided through the public health facilities – primary health centers (PHC), community health centers (CHC), and district hospitals (DH). The NGO peer educators mobilised the KPs to the clinic.

Avahan was community-centric from the beginning. Not only were all outreach workers from the community, other key NGO staff positions were also given to KPs. To ensure clinical services were KP-friendly, clinic administrators were selected from the community and trained to act as a bridge between NGO services and the community. Many community members who started as peer educators progressed to become Program Coordinators or Assistant Coordinators. Committees such as the Project Advisory Committee (PAC) and Clinic Service Review Committee (CSRC) were set up with a mix of NGO functionaries and community representatives to ensure quality services were provided with no stigma or discrimination. The collectivisation of KPs and formation of CBOs helped in awareness programmes, social events, legal literacy camps, health camps and sensitisation meets with service providers.

Community also played an important role in building an enabling environment. Hot-spot-level Rapid Action Teams (RAT) and NGO-level Core Advocacy Groups (CAG), formed with community representatives, were effective mechanisms to address the issues of harassment and violence; abuse by clients, community, or police; and stigma and discrimination by the service providers. The teams responded to any reported crisis within 24 hours. These community advocacy actions coupled with many sensitisation meetings organised for different service providers, especially police and healthcare providers, helped to reduce police harassments and raids.
All the activities were monitored through a user-friendly computerised monitoring information system (CMIS) that allowed individual tracking. Weekly and monthly plans were prepared at the site level, based on the data collected and reported. Specific formats were developed for tracking the KPs for service uptake and for micro-planning. Several studies were conducted along the way to understand the issues and make mid-course corrections wherever needed, ensuring that the programme remained evidence-based.

The last five years of Avahan implementation (2009 to 2014) witnessed several changes. First, the systems, budgets and human resources were harmonised with NACP III; CBOs were strengthened and six CBOs started managing TIs on their own; and government service providers were trained on STI management. Significantly, there was a shift from project-owned clinics to referral to government facilities. TIs constituting 10% percent of the population were handed over to APSACS in March 2009, 20% in 2011 and the remaining 70% in March 2012. Post-transition support by Alliance India continued until March 2013. Thereafter, community mobilisation activities for FSW were continued by Alliance India till March 2014.

Ten years of HIV prevention efforts have ensured that we have achieved our goals: increased consistent use of condom and improved health-seeking behaviour, as confirmed by a number of studies, including behaviour tracking surveys; and reduction in STI and HIV, as noted from the HIV Sentinel Survey and Integrated Biological and Behavioural studies. Community empowerment will ensure that these gains will be sustained.
Chapter 1

Stepping In: Pre-Avahan

In 2002, HIV prevalence in India was 0.8%, concentrated mainly among the high-risk groups, such as female sex workers (FSW), men who have sex with men (MSM), transgender persons (TG), and injecting drug users (IDUs). In a country of a billion people, even this relatively low prevalence meant India had the second highest number of people living with HIV (PLHIV) globally. UNAIDS had estimated 4.58 million people living with HIV/AIDS in India by December 2002, increasing from 3.5 million in 1998. The country had responded to the epidemic by starting the National AIDS Control Programme (NACP). The main focus of NACP I (1992-99) was on mass awareness to educate public on HIV transmission, safe blood transfusions and treatment of sexually transmitted infections (STI), while NACP II (1999-2006) mainly aimed to reduce the sexual transmission of HIV with a more focused approach through targeted interventions (TIs) for high-risk groups (HRGs). NACP II set up more than 1,000 targeted interventions for FSW, MSM, IDUs, street children, prisoners, truck drivers, and migrant labour. The TIs were implemented through non-governmental organisations (NGOs).
HIV Response in Andhra Pradesh

In 2002, more than 70% of HIV infections were concentrated in six Indian states, of which Andhra Pradesh (AP) shared a tenth of the burden. In AP, HIV prevalence was 1.62% among antenatal clinic attendees in 2002, and more than 400,000 people were estimated to be living with HIV/AIDS. HIV prevalence among antenatal women was 5% in the coastal district of Guntur, indicating clearly that the epidemic had moved to the general population as well.\(^1\) Prevalence of HIV among STD clinic attendees was as high as 40% as reported by 2002 surveillance results.\(^2\) Moreover, a study on FSW of Kakinada and Peddapuram found that HIV prevalence was 42% in Kakinada and 34% in Peddapuram, and syphilis was the highest in India.\(^3\)

To address issues of HIV, Andhra Pradesh AIDS Control Society (APSACS) initiated TIs in 1999. By 2002, APSACS was implementing 93 TIs in the state. At the same time, STI clinics, voluntary counselling and testing centers (VCTC) and prevention of parent to child transmission of HIV (PPTCT) services were strengthened and steps were initiated to improve access to free treatment, care and support services.

India HIV/AIDS Alliance in AP

To assist, plan and manage HIV response in Andhra Pradesh, the India HIV/AIDS Alliance (Alliance India) stepped in through its country office. The organisation’s strategic goal was to strengthen community action for prevention, care and impact mitigation efforts in India by doing the following: improving the coverage of effective community-focused HIV prevention efforts; strengthening leadership and capacity of civil society to respond to HIV; and improving institutional, organisational

---

1 HSS Report NACO 2002
2 UNAIDS 2002
and policy environments for community AIDS responses. Strategic priorities included home and community-based care and support, children affected by AIDS, positive and meaningful involvement of PLHIV, focused prevention with key population groups, and community mobilisation to facilitate ownership and sustainability of HIV prevention efforts.

In 2002, Alliance India implemented the Frontiers Prevention Project (FPP) and Avahan - India AIDS Initiative in Andhra Pradesh to focus on prevention activities among key populations (KPs). The aim of the FPP (2002-2006) and Avahan (2003-2014) programme was to reduce STI/HIV among key populations including FSW, MSM, TG, and IDU across the Rayalaseema and Telengana regions of the state. Complementing each other, FPP and Avahan contributed towards an effective response within the state and played a major role in changing the way targeted interventions were implemented in the country.

**Frontiers Prevention Programme**

Frontiers Prevention Programme (FPP) was a global initiative of International HIV/AIDS Alliance funded by the Bill and Melinda Gates Foundation (BMGF). It aimed at reducing HIV infections in low-prevalence countries with concentrated epidemic. By focusing prevention efforts on people living with HIV (PLHIV) and those most likely to be infected, it was hoped the program will have a dramatic impact on the epidemic in low-prevalence countries at a fraction of the expense that AIDS has already cost in the most affected countries. The entire approach to the FPP was based on the principle that meaningful participation and mobilisation of the community members in implementation of programmes increases the efficacy and uptake of the services.

**Framework of FPP**

In 2002, BMGF supported the implementation of FPP in Rayalseema and Telangana regions of Andhra Pradesh with a local NGO, called LEPRA Society, as the lead partner. Following a rapid mapping of key population in the state, a total of 26 sites were selected
in Rayalseema and Telangana in consultation with APSACS and BMGF based on the presence of KP groups; of these 14 sites were randomly selected for FPP interventions and other 12 were to be the control sites without any services, for comparison to assess the impact of the intervention.

**Participatory Site Assessment**

Community mobilisation in FPP was planned through the method of Participatory Site Assessment (PSA). The purpose of PSA was to mobilise KPs in project sites and to inform them about the FPP intervention services. In addition, through PSA, site-specific information on the size of the KPs, their characteristics, and their HIV-related needs was collected to facilitate site and population-specific intervention design. Local KP members were significantly involved in this process. The PSA process was led by LEPRA India and training on implementation of PSA and technical support for the process in the field was provided by Alliance India. PSA was carried out in two phases between 2002 and 2003. Programme representatives from different KP groups were selected and trained to facilitate community mobilisation and social capital building. On the basis of the KP population size as estimated in PSA Phase I, it was decided to initiate focused HIV prevention activities in 14 sites in Telangana and Rayalseema. There were no prior HIV prevention programmes being implemented by APSACS in these sites. The intervention covered nine districts of the region; the key populations included FSW, MSM, IDU and PLHIV.

**FPP Merger with Avahan**

In 2003, BMGF initiated a large scale HIV prevention programme in India in all six high prevalence states (Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu, Manipur, and Nagaland). The programme, called Avahan-India AIDS Initiative, was also aimed at reducing HIV infections in these high burden states by working with the high risk populations (FSW, MSM, TG, hijras, and IDUs) and clients of sex workers. A state lead partner (SLP) was selected for each state to implement the programme through NGOs and community-based organisations (CBOs). In AP, Alliance India was the SLP for Rayalseema.

**Maps Developed as Part of PSA Activity**

*Composite Map*  
*Broad Map*
and Telangana regions while Hindustan Latex Family Planning Promotion Trust (HLFPPT) was the SLP for the coastal region.

As per the proposal, the Avahan programme was to be implemented in 40 priority sites across AP as identified in consultation with APSACS and BMGF. The sites were later reduced to 38. These included 26 sites where PSA had already been carried out under FPP. Another 12 sites were selected based on the mapping done by TNS-Mode, a research firm. Initially, the term 'site' was not clearly defined and included multiple mandals with populations ranging from 50,000 to 1.5 million. However, owing to confusion among various partners, by 2005 each mandal was taken to be a site; this increased the total sites to 74 where FPP and Avahan were to be implemented.

**Changes in the Implementation Plan**

Several changes occurred in the design of the implementation plan of FPP during the Avahan planning process. The BMGF, Alliance India, APSACS and LEPRA developed a consensus that FPP and Avahan will have to be implemented together. The 12 sites that were originally designated as control sites for FPP now received service package as per Avahan design, thus eliminating the control sites for FPP. Since at that stage the Avahan service package did not include community mobilisation and enabling environment for vulnerability reduction, Alliance India proposed to group the sites into three cohorts, each with slight variations in intervention package:

- **Cohort 1** had 14 FPP sites. Alliance India proposed to continue FPP implementation in the selected 14 FPP sites with additional support from Avahan for project-owned STI services and condom social marketing.
- **Cohort 2** had 12 Avahan Sites. Three KP groups (FSW, MSM, IDU), which were earlier planned as FPP control site, were provided service package as per Avahan design with added services of voluntary counselling and testing (VCT) and intensive community mobilisation.
- **Cohort 3** also had 12 Avahan Sites. Three KP groups (FSW, MSM, IDU) entirely led by NGOs (with no PSA) were provided service package as per Avahan design. These sites had no HIV prevention programming in the area.

All these groups were managed by local NGOs. Rather than through referrals, STI services were planned and delivered by project-owned STI clinics. The Avahan interventions consisted only of providing NGO-led HIV prevention services, i.e., behaviour change communication (BCC), outreach, condom provision, and STI diagnosis and treatment, while FPP focus was on community mobilisation and creating enabling environment through social capital building to promote the prevention services. These additional and key community-led activities and services were expected to make a critical difference to the effectiveness of the response to the epidemic.

Alliance India’s implementation of TIs under FPP and Avahan brought in an era of unprecedented focus on community-centric programming. Both the programmes provided
a voice and a platform to the community to handle issues on their own and created an environment for them to practice safe sex and prevent HIV transmission. Some of the highlights of the two programmes included:

- Community led outreach using outreach workers were from the community.
- Community mobilisation through participatory site assessment (PSA).
- Community monitoring systems to ensure KP-friendly services, e.g., Clinical Services Review Committees (CSRC) and clinical administrators, who were selected from the community.
- Development of colour coded packs for syndromic management of STI.
- KP led core advocacy groups to lead advocacy efforts.
- CBOs managing TIs and community groups managing various components of TI.
- Micro-planning.
- Legal literacy and community led advocacy.
- Sexual and reproductive health (SRH) integration with HIV management at a policy level.
- Formal linkages with ICTC and ART centers and extending care and support services to HIV positive KPs.
- Building social capital through activities, such as photo-voice where KPs were trained on photography, not only offered a platform to community members to express themselves but also provided the necessary impetus to think of alternate and additional professions to reduce their dependence on sex work.

In Phase II of the programme (2009-2014), the ultimate goal of the project was to transfer the programme funding and management to the government and the communities by the end of 2014. Alliance India TI Program was transitioned to SACS and the communities in a phased manner from 2009 to 2012. A systematic Post Transition Plan was developed and implemented to further strengthen capacities of NGOs/CBOs to sustain the prevention impact among sex workers and MSM/TGs.

**Changes in Programme Management**

LEPRA India was the lead partner for FPP implementation when the programme started. They carried out PSA and recruited 27 technical support staff (TSS) from within the KP groups to lead community mobilisation activities. Training was given to the TSS to enable them carry out following roles and responsibilities:

- Facilitate community mobilisation
- Create safe spaces
- Raise awareness
- Promote condom use
- Refer individuals to KP-friendly STI clinicians

However, once Avahan grant was received, a regional office was set up in Hyderabad by Alliance India for Avahan and FPP implementation in November 2003 on the behest of BMGF. Avahan was to be managed by Alliance India through its regional office in AP.
with the country office in New Delhi and the international secretariat in Brighton having a technical support role.

In the original proposal of Avahan, LEPRA India was envisaged as the key partner to manage Cohorts 1 and 2, leading the implementation of community based social capital activities through community groups. LEPRA was to provide financial and technical support to KP groups for community mobilisation and social capital activities. Since these community groups were informal and unregistered, there was to be no forward granting by LEPRA while Alliance India had to contract NGOs and CBOs for programming. The whole change in the conceptual framework of FPP due to Avahan roll out, coupled with slow progress in community-led activities, had led to considerable delay in implementation of FPP activities. However, BMGF had insisted on Alliance India setting up a regional office in AP to manage Avahan programme. This led to management of FPP also passing from LEPRA to Alliance India. Therefore, the FPP agreement with LEPRA was ended and converted into a Framework Agreement. This transition of management was completed by June 2005. LEPRA subsequently became an implementing NGO for the Alliance India in six sites (Hyderabad, Hyathnagar, Kamareddy, Ramayanpet, Nirmal, and Sangareddy).

The role of Alliance India’s Andhra Pradesh office was as follows:

- To identify, short-list and assess NGOs/CBOs in Rayalseema and Telengana.
- To provide technical and financial assistance to NGOs and CBOs to respond to the epidemic in Rayalseema and Telengana.
- To facilitate capacity building of KPs/CBOs/NGOs/other service providers on an ongoing basis.
- To ensure transparency, accountability, and value for money in grant management by implementing necessary systems and procedures and by ongoing monitoring against milestones.
- To document and disseminate lessons learnt/good practices and to set up and encourage the adoption of quality controls and minimum standards.
- To support the formation of formal and informal networks of KP, CBOs, NGOs, and other stakeholders.
- To take a lead in advocacy at different levels to reduce stigma and improve service provision to KPs.
- To ensure consistency with International HIV/AIDS Alliance and India HIV/AIDS Alliance on policies, programs and approaches.
- To ensure ongoing collaboration and co-ordination with APSACS, BMGF and all other Avahan partners to ensure the following:
  - Consistency and congruence with national and state level HIV/AIDS policies, programs and strategies.
  - Cross-learning.
  - Mutual support/assistance.

Recruitment of full staff was completed in early 2004 with a full time executive director, a project coordinator, a training officer, programme officers, and finance director and
accountant. The clinical component was managed by the Delhi team and overall technical support was provided by Delhi and Brighton consultants. The contract with LEPRA was ended, and the TSS were slowly absorbed in the projects as outreach workers, clinic administrators or outreach supervisors, continuing their community mobilisation responsibility.

**FPP Evaluation**

A baseline study in the form of a survey through a questionnaire and a qualitative study was carried out for baseline of outcome impact evaluation. The baseline survey was carried out through broad mapping in 2003-2004 by Administrative Staff College of India (ASCI) in all 40 sites of Rayalseema and Telangana identified with high numbers of FSW. A total of 6,648 FSW and 6,661 MSM were interviewed through a questionnaire and their blood and urine samples were collected for testing for STI.

A huge variation on condom use practice was reported by the FSW and the MSM across the sites. Lack of knowledge that HIV can be prevented, and poor social support, had the strongest association with no or inconsistent use of condom among both the groups. In this study, 47.6% of FSW and 56% MSM reported either no condom use with clients at all or used it inconsistently. Regular sex partners were reported by 55% FSW and 94% of these did not use condom for penetrative sex with this partner. In addition, 50% MSM had sex with at least one female in the last three months, of which 84% did not use condom for penetrative sex with female. The study results were published in many peer reviewed journals.

The qualitative baseline study was carried out by the Institute of Health Systems, Hyderabad (IHS) in 2005. Focused group discussions with 16 groups of FSW and MSM each, and 118 in-depth interviews (IDIs with 32 FSWs, 32 MSMs, 16 PLHAs, 24 gatekeepers, and 14 NGO staff) were conducted for the study in eight randomly selected sites-four FPP intervention sites and four Avahan sites. Through the study, knowledge, attitude and behaviour of KPs towards HIV prevention, self-efficacy and self-esteem, experiences of stigma, discrimination and violence, social capital, involvement/participation in services, views of quality of services, and awareness/effectiveness of site-level approach were explored.

Generally, low level of trust and influence were reported in respondents’ social relationship within the informal network (family, friends, peers, partners and gatekeepers) as well as in the community groups. The relationships with key service providers (police, health professionals, political organisations, panchayats, etc.) were generally characterised by lack of support, stigmatisation and discrimination and at times violence. While most of them, especially the PLHIV, reported outreach workers (ORW) to be the key person in whom they could confide, the larger peer community was seen as untrustworthy. Inability to help others in case of abuse, and the fear that other peers may entice the partner might had attributed to this negative attitude. Low self-worth on account of feelings of
inferiority was seen across all KP groups. Generally, poverty, lack of education and regular employment, stigma and discrimination, and engagement in sex work were seen to be at the roots of feelings of inferiority. There was lack of cohesiveness due to existing differences and a general lack of trust between the members of community groups. As a result these groups were unstable and members moved from one group to the other. KPs from all groups did not wish their identity to be revealed outside the NGO staff. Involvement of KPs with the NGOs was not on account of health issues but more to address the needs related to violence and abuse reduction and livelihoods.

These findings informed and helped in improving the Avahan programme.

Programme Implementation Plan of Avahan

Implementation of activities at the site level was carried out by local NGOs contracted by Alliance India. Contracting of NGOs was considerably delayed due to revision in the conceptual framework of FPP and later due to the time taken for establishing Alliance India office in AP, recruiting full-time staff, and due to contracting of NGOs. As suggested by BMGF and APSACS, recruitment was done for both FPP and Avahan NGOs at the same time. First set of six NGOs covering 12 of the 14 FPP sites were contracted in April 2004. In June 2004, Alliance India put in place a rapid emergency scale-up plan. In July 2004, another cohort of 18 NGOs was contracted for FPP and Avahan implementation in nine districts.

In June 2004, it was decided to combine Cohort 2 and Cohort 3 and community mobilisation and vulnerability reduction components were introduced across all sites. As a result, there was programmatic integration of FPP and Avahan. The service provision for all three cohorts was undertaken as per the Avahan design, while KP-led activities and social capital-building under the FPP were mainstreamed in Avahan. Thus, the differences in the intervention for the three groups were completely eliminated except for the fact that FPP sites continued working with PLHIV until 2008 when FPP ended.
BMGF initiated the world’s largest HIV prevention programme, Avahan-India AIDS Initiative (Avahan, in short), in India in 2003. Avahan, meaning “call for action”, had the primary goal of preventing the spread of HIV in India through building an HIV prevention model at scale. The programme was implemented in six states (that accounted for coverage of 83 districts) and covered 220,000 FSW, 80,000 MSM/TG and 18,000 injecting drug users in 83 districts. In addition, five million men at risk (truckers and clients of sex workers) were also provided HIV prevention services.
Avahan was launched in AP in December 2003. In AP, there were two state lead partners to lead the program – India HIV/AIDS Alliance in Rayalseema and Telangana regions, and HLFPPPT in coastal districts. Alliance India’s proposal and program design underwent many changes in consultation with BMGF to align with the FPP interventions already initiated in the state. The programme was implemented in two phases between December 2003 and July 2014. The Phase I was implemented from December 2003 to March 2009, and Phase II from April 2009 to July 2014. While the first phase was about providing quality HIV prevention services, vulnerability reduction and community mobilisation to bring a sustainable change in risk behaviour of the vulnerable population, the second phase was about consolidating the gains from the first phase and establish sustainable models for HIV prevention for all the KPs.

**Objectives of Phase I**

Alliance India, through Avahan, aimed to achieve the following objectives in Phase I:

- Reduction of STI prevalence among sex workers (female and male) in 40 designated sites across Rayalseema and Telengana regions of AP by 2008.
- Increased condom usage among sex workers in these sites.
- Increased condom usage and reduction of STI prevalence among clients of sex workers in these sites.
- Increased empowerment of key populations and creation of enabling environment for effective HIV/STI prevention and care in the designated sites of Rayalseema and Telengana by 2008.
- Increased capacities of Alliance India supported NGOs and CBOs to implement effective prevention and care programs, and through training initiatives to build necessary skills to sustain the program efforts beyond 2008.
- Provide evidence through research and evaluation by 2008 to demonstrate the impact of Avahan prevention efforts and of supplementary VCT care and community mobilisation through monitoring and evaluation (M&E) in specific sites.

**Expected Outcomes**

By the end of 2008, Alliance India hoped to achieve the following outcomes:

- Reduction of curable STIs to 15% among sex workers in designated sites.
- 80% of sex workers report consistent condom use in designated sites.
- Reduction of curable STIs to 15% among clients of sex workers.
- Alliance India-supported NGOs and CBOs strengthened to implement effective HIV/STI prevention and care programs.

**Objectives of Phase II**

Goal of Avahan Phase II: Documented impact on India’s HIV/AIDS epidemic and response in target geographies by building a scaled model of prevention with high risk groups and transferring it to government and communities for sustainability.
To consolidate HIV/AIDS prevention impact among FSWs, MSMs and TGs by the end of 2013 in the selected/agreed districts of AP.

To build and capacitate communities, their institutions and NGOs to ensure HIV prevention programs and vulnerability reduction efforts are sustained post-transfer to government and other funding agencies.

To transfer program funding and management to government and other stakeholders.

To create knowledge base for scaled HIV prevention and document and disseminate lessons learned.

Geographical and Population Coverage

Originally, the Avahan interventions were designed for sex workers and their clients alone. In addition, reaching out to 466,000 clients of sex workers was also planned. Later, however, BMGF separated the interventions for core groups (FSW, MSM and male sex workers) and bridge populations. Separate interventions were launched by BMGF to reach out to bridge population (clients of sex workers, truckers), and a decision was made that the sex worker interventions will focus on the sex workers and their regular partners and not on the clients. Alliance India decided to include all self-identified MSM and transgenders of the areas in the ambit of the program as baseline survey clearly showed that even though only 49% of MSM indulged in sex work, all had multiple partners (average partners three), and condom use was low (43%), making them vulnerable to HIV risk. Moreover, by June 2004, Avahan decided to extend the additional FPP interventions of collectivisation and community mobilisation to all sites, and not just a subset.

Minimum Package of Interventions

The interventions combined strong elements of community led programming from the FPP and strong STI service component of Avahan and intended to provide a comprehensive service package that included:

- Behaviour change communications (interpersonal and mass communication).
- Prevention services (STI services and primary health care; needle/syringe exchange for the IDU).
- Condom promotion.
- Advocacy and research.
- Capacity building of NGOs to implement HIV prevention programs.

Programme Strategies
The following were the key program strategies used in implementing Avahan:

- **Behaviour Change Communication (BCC):** The communication strategy was designed to increase the demand for information and services related to HIV prevention and STI treatment and management and to increase self-risk perception, reduce risk behaviour and improve health seeking behaviour among the KPs and their partners.

- **Provision of Quality STI Services:** Comprehensive STI management is fundamental to HIV prevention programming. The STI control strategy included provision of both STI management (diagnosis and treatment) and prevention (counselling for adherence to treatment, partner treatment and condom promotion). The services were provided through:
  - Project-owned static clinics, mobile clinics, and outreach/mobile camps.
  - Referral to STI service providers in the private and public sectors that are identified by the KPs, including accompanied referrals.
  - Mythri Mainstreaming Model through which services were provided by public sector healthcare facilities in partnership with NGOs.

- **Condom Programming:** Condom strategy included distribution of both free and socially marketed male condoms to all groups of KPs. The free distribution of condoms was done through peers, outreach workers during their contact with KPs in the field,
through STI clinics, and through outlets in various hotspots. A special pack of condoms and water based lubricant (Mythri condom pack) was developed for social marketing through outreach workers, community based groups and CBOs.

- **Community Mobilisation and Social Capital Building:** Community-centric approach has been the hallmark of Alliance India’s interventions in AP. Intensive community mobilisation through PSA was continued through social capital building activities that included collectivisation and promoting mutual support, networks and solidarity among the KPs. It was believed that community empowerment through sharing and pooling of knowledge brings in sustainable change, increases community awareness of their rights of basic social and economic service, and strengthens their ability to claim these rights.

- **Advocacy and Policy Initiatives:** District and sub-district level advocacy plans were prepared to address the issues listed above. Alliance India believed the involvement of KP leaders was crucial to successful advocacy work and policy development. KPs were seen as the most important driving force for district and site level advocacy. For this, the Alliance India and local partner NGOs built capacities and provided critical support on an ongoing basis. Core Advocacy Groups (CAG) were created to address KP issues of violence and discrimination. Advocacy efforts were led by NGOs, KP representatives and Alliance India staff and aimed at the police, the media, gatekeepers, government officials, and healthcare providers. Guidelines were prepared for NGOs for development of district and local advocacy plan, mapping of local and district power structure, and clear objectives for each stakeholder category. For media advocacy, an external partner, called Center for Action Research (CFAR), was engaged to support Alliance India and other SLPs of Avahan.

- **Capacity Building:** One objective of interventions was to build the capacities of local NGO and CBOs to manage HIV prevention and care interventions for the KPs. A cadre of trainers were developed from the NGOs and community representatives on different themes. NGO capacity assessment tools (NCAT), developed by International HIV/AIDS Alliance were used to assess capacity building needs and evaluating impact of capacity building. Training was provided through central and site level training workshops, intense on-site technical support by the program and technical officers, exposure visits, developing manuals, guidelines, and tool-kits. In addition, Avahan provided capacity building support through technical support organisations or consultants. These included Family Health International (FHI) for STI and M&E, PATH for interpersonal communication; CFAR for media advocacy; and CARE for community mobilisation.

- **Monitoring, Evaluation and Research:** Robust data collection and reporting system against a set of core indicators was developed right from its inception to assess program performance at regular intervals, identify the areas of improvement and make programme adjustments. KP led monitoring systems were planned to complement the program monitoring through monitoring information system. These community monitoring systems included quality assessment of clinical services (Clinic Service Review Committee), periodic rapid mapping exercise, participatory site assessments, and feedback from KPs (suggestion box in drop-in center and exit interviews in the clinics).
More details of each of these strategies are provided in the respective chapters of this report.

**Programme Management**

**Mapping and Scale Up:** First mapping of key population in AP was done in 2003 by the state, based on which 38 sites were prioritised for starting the focused HIV prevention programs in Rayalaseema and Telangana. Once the NGOs were recruited, rapid mapping was done by each NGO to estimate KP size and know their exact location and characteristics. In 2005, a formal mapping exercise was done in all the mandals by IMRB and TNS-mode. This was both a quantitative and qualitative study, exploring not just the size estimation of FSW, MSM, TG, and IDU, but also the perceptions of the community about the services and their awareness regarding safe sex, STI and HIV. The study was done in seven districts (Karimnagar, Kurnool, Anantapur, Khammam, Nizamabad, Chittoor and Warangal). Later in 2006, TNS-mode undertook mapping exercises for the entire state of AP. The report showed a number of areas with key populations that were not covered by the programme. Based on the numbers and to saturate coverage of KPs in four districts (Anantapur, Chittoor, Khammam and Warangal), the decision was made to scale up interventions from 74 mandals in 2005 to 139 mandals in 2007. Scale up strategy was put in place in March 2007 and by end of 2007, the program was reaching out to 50,000 KPs through 33 NGOs in all 14 districts of the region.

**NGO Selection:** The HIV prevention interventions of Avahan and FPP were to be implemented in 38 sites of Rayalaseema and Telengana regions of AP through 35 local NGOs. The process of NGO recruitment was initiated in December 2003 in the 26 sites where PSA had been carried out following a rigorous selection process:

- Compiling a list of NGOs from different sources (newspaper advertisement for expression of interest and word of mouth).
- Screening the NGOs based on experience, reach, programmes being implemented by a team comprising of external consultant and members of internal cross-disciplinary team.
- Contacting the screened NGOs for expression of interest along with documents required for statutory compliance.
- Review of documents by the internal team and further short listing of NGOs.
- Visit and review of the short listed NGOs by the team and assessment of NGOs based on NGO technical assessment and financial capacity assessment tools by team members independently.
- Compiling individual assessments and finalising the NGO selection.
- Proposal development with selected NGOs and contract signing.
The process followed was long and slow as the NGOs had very limited or no experience of working in the field of HIV and none with key populations. Orientation training was provided to the NGOs followed by proposal writing. By June 2004, only six of the 26 NGOs had been contracted. Next batch of 18 NGOs was contracted in July 2004. Alliance India always felt that NGO selection and basic training was affected – NGOs in two sites (Nizamabad and Andole) had to be discontinued within a year due to performance issues. By April 2005, another set of NGOs were contracted: AIRTDS, Lepra Nirmal, ANKITA, PAID and PEACE.

Structure of Alliance Andhra Pradesh Team

The Alliance AP staff went through a number of changes in the structure and management. Started as a regional office of India HIV/AIDS Alliance, an initiative was undertaken to establish it as an independent NGO and a Linking Organisation (LO) of the International HIV/AIDS Alliance. While the decision to become an independent NGO was being formalised, scale up of interventions was ongoing.
The organisation was headed by an executive director who provided strategic leadership for implementing the FPP and Avahan programmes. Broadly, four units were created, namely, programme, clinical, technical (capacity building, advocacy, communication, and M&E), and finance and administration. Each unit was headed by a director, a member of the senior management team, with mid-level managers and program or technical officers. The roles and responsibilities of each team were well defined. Whereas the program team was responsible for overall program management in their respective areas through programme officers, the clinical team was responsible for managing STI component of the program. With scaling up of sites and programme, number of staff managing the TIs also grew. (See page no. 108 for Alliance India Avahan Team.)

Alliance for AIDS Action (AAA), the new organisation, was launched finally in May 2008. However, the organisation growth was affected by many factors. In 2010, the governing board of AAA was dissolved and organisation once again became the regional office of India HIV/AIDS Alliance.

Process of Program Management

The program officers led program management at the NGO level and were responsible for grant management and contracting, supporting annual proposal development, monitoring outreach as well as overall NGO performance, and coordinating with capacity building and technical teams to ensure capacity building initiatives are undertaken as needed.

- Each TI was visited at least once in a month by the program team and once in a quarter by the clinical, M&E and finance teams. Monitoring by each team was done on the prescribed tools and a trip report detailing observations, on-site support provided and actions recommended was prepared on a prescribed format and shared with senior management, other team members and the NGO visited. NGO had to provide an action-taken report once the recommendations were acted upon.
- Training needs were assessed through capacity assessment tools developed by the capacity building officer. Apart from basic trainings to NGO staff at the time of contracting, refresher trainings on all components were given to respective staff of NGO every year.
- Programme guidelines were prepared on each component and shared with the NGO staff. Revisions in the programme were based on evidence from various studies and were communicated to all partners.
- The monthly reports received from the NGOs were reviewed by the program and clinic teams together and feedback was provided to the NGOs. This also provided an opportunity to review their monthly progress.
- A quarterly review process was put in place, where programme, clinical and finance teams reviewed partners’ reports, both programmatic and financial, and shared feedback along with any work plan or budget adjustments.
• The performance was reviewed biannually in review and re-planning exercise. At the end of the year, planning for the next year was done based on performance during the year while the mid-year review helped in identifying gaps and provided opportunity for mid-course correction in plans, if needed. The NGOs also had annual, mid-year and periodic reviews. There were reviews with BMGF as well as at the SLP level.

• Finance officers visited the NGOs regularly to ensure all systems were in place and there was no misappropriation of the funds. Internal coordination between all teams was facilitated by weekly team and inter-team meetings and sharing the observations of field visits.

• Internal coordination between all teams was facilitated by weekly team and inter-team meetings and sharing the observations from the field visits.
A key element of the Avahan programme, outreach ensured that services of focused prevention reach all members of key populations, who are at times hidden and difficult to reach. The outreach services included behaviour change communication, distribution of commodities like condoms, lubes and IEC material, provision of information and referral for STI/HIV services, community mobilisation, and peer counselling. The outreach strategy of Avahan was based on direct regular contact with the KPs on a one-to-one basis and through group meetings.

The following were the key strategies for the outreach component of Avahan:
- Establishing systems for outreach
- Outreach planning
- Microplanning
- Drop-in-centers
- Condom promotion
- Capacity building
Empowering Key Populations for Sustainable HIV Prevention

**Evolution of Outreach**

2004
- Recruitment of community members as ORWs

2005
- PE strategy included in CMP
- Recruitment of PEs initiated
- Mythri condoms and lubes initiated

2006
- 738 PEs recruited and 5-day Training of PEs at local level
- Outreach strategy document
- Field coordinators to supervise ORW. TSS transitioned to FC
- Condom gap analysis and social marketing of Mythri packs
- Training on MT to Khammam and Anantpur

2007
- Scale up of sites and population
- ORWs and PEs scale up accordingly
- Training through TOT
- Scale up of MT to other districts

2009
- Simultaneous training of 415 ORW and 1,421 PEs (four day refresher training, Suchetna) through regional TOTs.
- FC withdrawn

2010
- Alignment with NACO operational guidelines
- Illiterate ORWs replaced by literate ORW trained as peer counsellor
- Training of ORWs and PEs on C & S
- PE/KP ratio increased
- Andarikosam and Manakosam

2011
- 20% transition
- Training of ORW and PEs on new data collection formats

2012
- 70% Transition
Establishing Systems for Outreach

In 2004, as NGOs came on board to implement HIV prevention activities in different sites, outreach workers (ORWs) were recruited to provide information to the key populations in their areas and to mobilise them to the Mythri centers. They were selected from within the community. By April 2005, Avahan adopted a peer education strategy to enable quality BCC to reach the key populations through more frequent contacts. Peer educators (PE) were selected based on hot spot population and social network mapping and they worked four hours a day, with no travel involved, for outreach with peers from the same hotspot. Roles and responsibilities of the ORW and PEs were spelt out clearly to rule out overlap and to facilitate supportive supervision of PEs by ORW. Outreach strategy document was developed in 2006 and guidelines were shared with all implementing partners. Each PE/ORW was given a field kit that contained flip book, penis model, and condoms. During their contact with KPs, the outreach team built the skills of KPs for correct use of condom as well as on how to negotiate condom use with their partners. In addition, they collected data, collated, reviewed and used the data for their weekly planning. From 2007, PEs were trained to screen the KPs for TB through simple questioning (verbal screening) during their field contact and referred the suspects to Mythri clinic for further investigation.

A total of 210 ORWs were recruited in 2004 for 19 sites by 18 NGOs. Each ORW was to contact 25-30 KPs at least twice during each month. PE recruitment started in June 2005 and by 2006, a workforce of 370 ORWs and 738 PEs was in place, with PE/KP ratio of 1:40 to 1:50. This number increased to 1279 PEs and 414 ORWs by 2007-08 after the interventions were scaled up to 139 sites and 34 NGOs and PE/KP ratio increased to 1:60. Field coordinators (FC) supported the project coordinator (PC) in monitoring outreach and data collection and collation by ORWs. FC reported to the PC not only on ORW performance but also on the external environment issues that acted as barrier to safe sex practices (such as harassment from rowdy, police, partner, etc.), and accessibility, availability and quality of services.

Outreach Planning

ORWs were responsible for the ground level planning for outreach and this started right from PSA. Micro-planning was an essential tool that assisted in outreach planning and implementation. Following tools were used for outreach planning:

**Mandal Maps**, prepared during PSA, showed distribution of hotspots in relation to various landmarks of the area along with resources available was. The local facilities and resources were marked on this map.

**Hotspot Maps** were prepared showing the number of KPs estimated and contacted and their mobility pattern. Separate maps were prepared for FSW and MSM and displayed at the DIC. The hotspots, the places where sex is solicited (such as bus stations, parks, public toilets), along with the estimated and contacted number of high-risk individuals at
each location were marked on the maps. This mapping also helped determine the number of peers required at each area. At the same time, PC created hotspot-wise data based on KPs estimated contacted (line listing). This information was updated on a quarterly basis.

**Social Network Mapping:** Each ORW/PE created their social network maps, listing the unique identification (UID) numbers of the KPs in their direct contact and then friends of each of these contacts. Believing that this network connection of the peer educators and outreach workers could be effectively used to pass on the communication of safe health or for maximising the mobilisation, the social network tool was developed and modified to understand the risk of all KPs involved in the network.

**Microplanning**

Both weekly and monthly meetings were held among the ORW, PE, PC and the clinic ANM; in the meeting, the outreach and clinic data (information on people who are due for regular check-up or follow up or partner notification) was analysed to understand the gaps in outreach and clinic services and accordingly outreach plan for the coming week was developed. The weekly planning was done by each ORW supported by field coordinators and PC. Based on the mapping and priority issue analysed for each KP, PE decided what message was to be given to each KP during their one-to-one contact in the field.

In 2005, a weekly tracking tool was developed to facilitate prioritisation and ensure every KP receives prevention services. A few NGOs developed their own tracking tools to ensure PEs prioritise their one-to-one meetings and meet their entire target population at least once. These tools were later adapted by Alliance India and shared with all other NGOs. The tools helped PE to understand each KP’s needs and provided services accordingly. Also, a clinic tracking tool to monitor the service availability by the community was maintained by the ANM.
Mapping of STI Services: In 2008-09, STI mapping was added to microplanning to ensure saturated coverage of KPs to ensure accessibility of clinical services by all the KPs. The distance between different hot spots and Mythri clinics, government clinics and private clinics was mapped and number of KPs available in the hotspots and number of KPs accessing the clinic services were noted. Reasons for not attending the clinic were analysed and wherever distance was an issue an alternate approach to Mythri clinics was explored. Health camps were proposed if no other facility was available within a radius of two kilometers. These maps also helped in resource mapping for mainstreaming of STI services while aligning with NACO guideline, especially for scattered population as DIC-based static clinics was approved for projects with population of more than 1,000.

In addition to the regular contact of PE, KPs were also outreached using campaign approach. Monthly events were held in the DIC with simple message on a theme (e.g., VCT, CBO launch, legal literacy, etc.). Additionally, the community members were mobilised to the DIC to celebrate festivals or initiate rituals (Rishta, etc) for the MSM and the occasion also used to provide information and services on STI.

Drop-in Centres

The concept of Drop-in Centres (DIC) was established in 2004. The DIC was meant to be a safe space for the community and could be utilised by the KPs to rest, dress themselves up, and share their joy and sorrows with fellow community members. It was also utilised as a safe place for information dissemination, condom distribution, collectivisation activities for the community. The community had a pivotal role in identifying a DIC that were near to the hotspots for accessing needed services by the community.

In Alliance India’s sites, the community named the DICs as Mythri centers, which meant “a friendly place”. In many places, the Mythri centers housed STI clinics as well.
Empowering Key Populations for Sustainable HIV Prevention

The DIC space consisted of a room for relaxation with some games and TV for entertainment. Infotainment through digital and audio-visual media was also provided at the DIC. By 2008, there were 154 DIC in 139 intervention sites. Alliance India encouraged KPs to co-own the project-run DICs. From 2007, NGOs passed on the management of DICs either to community based groups (CBG) or constituted ‘DIC committee’ that monitored the functioning of the DIC. In a few projects, the KPs paid the rent of the DIC and were involved in its maintenance.

Condom Programming

One of the important functions of outreach teams was to promote condom use by the KPs to reduce their risk of acquiring HIV/STI. For this, not only condoms were distributed to the KPs but the skills of KPs were built on correct and consistent use of the condom through condom demonstration and enacted condom negotiation with clients and partners. Demand of each KP was calculated based on their number of sexual encounters per day and supply was met through free distribution supplemented by social marketing, ensuring all encounters are covered by condoms. Free condoms were distributed through PE and ORW in the field during their one to one contact; through DIC; ANM in the Mythri clinic when KP came for STI treatment or regular check-ups; and condom outlets strategically placed in different locations around hotspots.

Biannually, the NGOs carried out condom gap analysis that looked at average number of sexual acts versus the number of condoms procured by the KPs from all sources, including NGOs, market or socially marketed. The aim was to keep the difference between the two to zero. The process was initiated in 2006, starting with four NGOs and later adopted by all. The gap between condom demand and condoms provided reduced from five per KP in 2006 to 0.5 per KP by September 2008. This analysis helped the NGOs to estimate their requirement and ensured there was neither wastage nor shortage of the condom stocks.
Social Marketing of Male Condoms: Anecdotal evidence suggested that many KPs, especially the MSM, were not satisfied with the quality of free condoms. Moreover, they were using oils or creams as extra lubrication, resulting in high rates of condom breakage. So Alliance India decided to provide their own branded pack of condom, which came with an extra pack of lubricant, for the MSM. The brand was known as Mythri condoms. Each pack contained two condoms and two sachets of water based lubricant. A study was conducted by Synovate in 2006 to understand acceptability, accessibility, availability, and perceived affordability of Mythri condoms. Study was carried in four districts and feedback was sought from 1002 respondents (both FSW and MSM) who had been given Mythri condoms through ORWs two weeks earlier. Following the study, strategy for social marketing of the male condoms (Mythri brand) was developed. Social marketing of Mythri packs was initiated by the CBOs, CBGs, and NGOs located in 13 intervention districts of Rayalaseema and Telangana regions. A Mythri pack was sold for Rs. 3/- by an ORW/CBO member. An implementation plan was devised wherein the CBOs were to be capacitated in the first phase (2006) and in the second phase (2007), marketing channel were established and strengthened.

Social Marketing for Female Condom: In 2007, female condom, a barrier method that women can control and a relatively new product, was introduced at certain sites for social marketing. Training was provided to PEs, ORWs and CBO members on use of the female condom and was promoted as a method on which women had full control. However, soon it was evident that CBOs failed to popularise Mythri condoms and were not able to have the entrepreneur model for either female condoms or Mythri packs. Another study was then carried out to focus on the issues of scaling-up, replicability and willingness of the CBOs to take up the social marketing of Mythri condoms. Based on the findings, the social marketing strategy was strengthened.

Data Collection and Monitoring

Efficient and user friendly system was developed for capturing the data from field. Daily information was recorded by PE/ORW in their daily diary on the number of people met and provided HIV prevention information, whether referred to Mythri clinics for STI/HIV services, and number of condoms given. Daily diary was low literacy tool to enable the illiterate PE to capture the information accurately. This information was entered in computerised MIS (for details, see the chapter on M&E). In addition, DIC register recorded the number of people using DIC on a daily basis along with condoms distributed. Details of events organised in DIC were documented in this register. Records of condoms procured and distributed were maintained in condom stock register which was updated on a daily basis. In 2010, an SMS based tool was created to collect the condom distribution data from the field.

Field monitoring was done through field coordinators and ORWs on a weekly basis. They supported the PEs in skill building of the KPs for risk and vulnerability reduction. In addition, project coordinators visited the field regularly to monitor outreach activity as well as to provide support. Once in a quarter, the programme officers from Alliance India also visited the field and validated the data.
Capacity Building

In 2004-05, members of Alliance India staff visited each NGO and provided training to the outreach teams. The training team consisted of program officer, technical officer and M&E officer and provided information on STI/HIV, its transmission and relationship with STI, prevention and treatment of STIs, safer sex, condom use and negotiation skills. However, from 2006, as the number of PEs increased, training of trainers (TOT) approach was adopted to train this large workforce. In 2007 and then again in 2009, through TOT, more than 2,000 PEs and ORWs were trained. A Peer educator manual was developed as a resource material and flip charts, separate for MSM and FSW, were developed as job-aid for the ORW and PEs. A pictorial handbook on STI and handbook on key messages on HIV/STI prevention was also developed and translated in Telugu, the local language. The IEC material was developed in consultation with the KPs. From 2008 onwards, the post of Field Coordinators was discontinued with the outreach workers taking over FC roles and responsibilities to align with the Avahan structure.

Other significant capacity building events include Magnet Theatre (MT), an innovative interactive form of community theatre designed to enhance interaction and participation with audience and to help people to discuss community specific issues and probable solutions. It was adapted in context of HIV/STI for the key populations to help each core group understand risky behaviour and explore appropriate ways to reduce risk of HIV/STI. In 2010, a few CBOs organised “Andarikosam” a social event to build team spirit and improve common understanding about project services, enabling environment and community mobilisation. A total of 165 PEs participated in the event and shared their experiences and
work performances. Similarly, “Manakosam” was a capacity building event organised for ORWs to build capacities in micro-planning tools and emphasise their role in monitoring the PE performance. All ORWs presented their performance on key indicators and the event helped in improving their planning and monitoring skill.

Study on Mythri Condoms: The study was conducted by Center of Media Studies (CMS) with 1065 FSW and MSM of 17 CBOs and 10 NGOs in eight intervention districts. The study revealed that most of the FSWs were using the free condom, with 25-30 percent using branded condoms including Mythri, depending upon the choice of client. However, most clients were not aware of Mythri brand as it was not publically marketed. Others were not satisfied with Mythri condom, finding issues with its elasticity. Moreover, since FSW did not use lubricants, they were not happy paying for lubricants and wanted Mythri pack to have three condoms instead. In contrast, MSM wanted to have only two lubricant sachet sold at the cost of Rs. 2/-. Neither FSW nor MSM wanted brand of condom changed in the pack. CMS study also explored awareness of FSW on female condoms – about two-thirds were aware of female condoms and 30% of those had used it occasionally. Cost was the prohibiting factor and they were willing to use it if female condoms were made available under Mythri brand with less cost. Since free condoms were available in sufficient quantity, Alliance India decided to separately procure lubricants and distribute it free to the CBOs for social marketing. Additionally, Alliance India also expanded the female condom programming to all of its intervening sites.

Condom Gap Analysis Study 2009: A study was conducted in 2009 to understand the issues of condom gap in four intervention districts to provide analytical information on the current situation of condom distribution and usage, and the perceived gap in effective usage of the condoms as safe devices. The study findings indicated that though the condoms reach the community members, efficient and effective distribution mechanism needs to be enthused into the distribution channels. The practice of KP through procuring condoms through PE and also picking up from DIC/clinic though encouraging as it denotes the need for condoms by the sex workers for safe sex practice, monitoring at project level was missing as to exact need of each individual and its effective use. A significant finding was the practice of excess condom distribution. To ensure smooth procurement system and avoid condom wastage, system was created with social marketing organisation PSI – weekly demand and requirement for condom was sent to PSI who helped in redistribution of surplus stocks of condoms.
Clinical Services

Management of STIs among KPs was an important component of the overall HIV prevention strategy under Avahan. A comprehensive strategy for STI service delivery was used by Alliance India and included all the elements of Avahan’s common minimum programme as well as additional service of AIDS care to the KPs infected with HIV.
Evolution of Mythri Services

2004
- NGO recruitment & Establishing Mythri clinics (static, satellite & mobile), ESWP, basic AIDS care, color coded packs, SCM of STI
- Presumptive treatment for NG/CT Xq
- CMIS introduced, clinic administrator

2005
- Laboratories established
- Syphilis screening (RPR), Hepatitis B, Pregnancy test
- SRH integration – 4 sites

2006
- Scale up of sites, population and services
- ICST introduced
- MM Model initiated to provide services

2007
- Transition of 10% KPs to APSACS
- Alignment with NACO operational guidelines
- Presumptive protocol changed
- Alignment with NACO costing guidelines
- Clinic administrators and counsellors removed; color codes aligned with NACO’s
- ORW trained as peer counselor
- Care and support integration

2009
- 20% transition
- SRH integration
- Data collection formats aligned
- Training of Govt medical officers and nurses (>500) on STI management and COGS

2010
- 70% Transition

2011

2012
Strategy for Implementation

- Establish program-supported clinics by implementing NGOs for STI diagnosis and treatment.
- Recruit and build capacities of medical and paramedical staff of clinical teams (doctors, ANMs, counsellors) by NGOs.
- Mobilise key populations to STI clinics through peer-led outreach.
- Deliver free STI diagnostic, treatment and counselling services to KPs and their regular partners through STI clinics.
- Provide free basic AIDS care to all those who are identified as HIV positive.
- Increase referrals and linkages.

Evolution of Mythri Clinical Services

The Mythri clinics were started with the objective of providing STI treatment to the KPs. As the programme matured, the STI component evolved significantly. The STI treatment package was supplemented with additional clinical services (treatment for general ailments, syphilis screening, sexual and reproductive health services, and basic AIDS care). Models of service delivery also evolved, ranging from static clinics to referral clinics to Mythri mainstreaming model.

First Phase (2004-2009)

Establishing STI Services

- **Mythri Branding**: A consultative meeting of all project staff members and community representatives, held to orient on the Avahan project strategies, decided to brand the STI clinic and DIC as Mythri centers. Mythri is a Sanskrit word for “friendship”. The community members in addition to branding, also designed a logo for the Mythri centers.
- **Resource Mapping**: A resource mapping of clinical services was undertaken at each site by respective outreach workers and community members to decide location and timings and the clinic doctors of the Mythri clinics.
- **Setting-up Clinics**: A service delivery model was developed to maximise the access to the services by maximum possible population and it depended upon the geographical area, local population size, and the mobility pattern of the KPs. Fixed location clinics (static and satellite clinics) were established in urban and periurban areas in rented space while mobile clinics were set up for population in the hotspots that were not easily accessible. In 2005, nineteen sites were served by program clinics while the remaining 21 sites were served by mobile and satellite clinics. The number of fixed-site clinics were scaled up in 2008.
- **Infrastructure**: DIC and STI clinics infrastructure (Mythri centers) were established simultaneously across all intervention sites. The location of the Mythri center and clinic doctors were identified based on the resource mapping as mentioned above. Willingness of the doctor to work with KPs was a criterion. Suitable space was rented ensuring a separate room for the counsellor, doctor and a waiting area so as to provide audio-visual privacy for counselling as well as medical consultation.
Equipment and Commodities: All clinics were provided the list of equipment and commodities (drugs, condoms and lubes) to be procured for provision of clinical services.

Drug Kits: To ensure correct and complete standardised treatment for STI across all the intervention sites, it was decided to pre-package the drugs for each STI syndrome in colour coded envelops. A specific colour was assigned to each kit containing drugs pertaining to a particular syndrome. The kit contained all the drugs required for treating all the organisms causing that particular syndrome as per NACO’s syndromic case management (SCM) protocols. Overall, Alliance India developed eleven STI packs, six for the primary syndromes and four for alternate/secondary options, and one for presumptive treatment. Systems were established for the NGOs to procure these colour coded STI treatment packs directly from the supplier.

Clinic Staff Recruitment: The clinic staff included medical officer, a nurse, and a counselor. In 2005, a community member was recruited for each NGO as clinic administrator to ensure KP-friendly services.

Minimum Clinic Standards: In order to maintain uniform standards across all clinics, STI guidelines and clinic protocols published by Alliance India in 2004 were used during the trainings of clinic and program staff. In 2005, WHO/FHI/BMGF developed STI Clinic Operation Guidelines and Standards (COGS) to ensure that STI Clinical Services across Avahan Program follow standard set-up and maintain good STI quality services. Based on COGS, a Minimum Clinic Standards guide was developed and shared with all NGO partners by Alliance India.

Capacity Building: Intense training was provided to the clinic staff through workshops that included hands-on skill building sessions on STI management as well as data management. The training content was based on WHO guidelines for STI management and separate trainings were organised for each cadre. The staff were also trained on sex and sexuality, issues related to MSM and TG, and primary HIV care.

Roll-out of Services: The KPs were mobilised to the Mythri clinics by the outreach staff who gave information about STI/HIV, the Mythri centers, the services available, and the timings of the clinic. Counsellors were trained to help KPs get over their fear of internal genital examination by showing the instrument and explaining the procedure. In addition, various other community mobilisation strategies were used to improve the clinic flow.

Coordination with Outreach: PEs and ORWs were trained to do the following:
- Identify and motivate people to visit the clinics for their regular STI check-up and early reporting of STI symptoms. During their one-to-one contact with community members, they provide information on STI, HIV and condom use and distributed the condoms. The PEs and ORWs led by example on the importance of mandatory STI check-ups by going for regular check-ups themselves.
- Promote community based follow-up for compliance
- Community based follow up for partner notification and management
In addition, various strategies were adopted to increase the clinic flow. These ranged from organising events at DIC to attract KPs to giving incentives to the ones who attended. Clinics were made KP-friendly so as to not make it a roadblock towards KPs clinic attendance. Some of the key issues that were addressed were rights-based stigma free services, maintaining confidentiality about the KP and his/her health status, and ensuring that the KPs feel safe in the clinic thus creating an enabling environment for them to access the services. Where the doctor was of the opposite gender, a health worker of the same gender as the KP was made available during examination, and at all times in the clinic along with the KP.

- **Establishing Referral Linkages:** Linkages were established with specialised service centers to facilitate comprehensive healthcare delivery. These included government healthcare facilities for complicated STI or other medical problems, care and support centers for the PLHIV, VCTC for HIV testing, and designated microscopic centers (DMC) for TB diagnosis. As the program matured, and focus on TB and HIV screening increased, referral systems with DMC, Integrated Centers for HIV Testing and Counseling (ICTC) and ART centers were strengthened.

- **Establishing Monitoring Systems:** To ensure quality data reporting from each clinic, uniform data collection tools that included clinic attendance form (history and examination findings filled by doctors) and client encounter form (KPs’ visit details in excel) were developed. A computer based MIS (CMIS) was developed and TI NGOs reported their clinic data in Alliance India specific CMIS. A community member was appointed as clinic administrator to ensure that the clinics deliver KP-friendly services, are sensitive to the needs of the KPs, and that quality clinic services maintained. The role of the CA, primarily, was to interact with the KP attending the clinic, allay his/her fears on STIs, ensure all protocols and standards of the clinics are followed, and that the KPs are satisfied with the clinical services. Level of satisfaction of KPs was monitored through systematic conduct of exit interviews. Also, a TI based committee (Clinic Service Review Committee) was set up from among community members and ORWs to meet quarterly to discuss and address concerns and issues related to clinics and provide feedback and recommendations to the NGO management. Alliance India technical team visited the clinics regularly (one clinic per quarter) to monitor and provide technical support to the clinic staff. Clinic Quality Monitoring Tool, developed by FHI, was used to assess the clinic performance of static clinics and Performance Standard Tool (PTS) was used for the referral clinics.

**Service Package**

The Avahan Common Minimum Program (CMP) defined the minimum services to be provided through the STI clinics under Essential Sex Worker Package. However, in Mythri clinics, the HRGs were provided some additional services as well which included treatment for general ailments to all KPs, and basic AIDS care to HIV positive KPs. A few clinics had also provided treatment to the children of sex workers as a strategy to increase coverage.
Empowering Key Populations for Sustainable HIV Prevention

Essential Sex Worker Service Package: This package included minimum package of services to be delivered to the key population community:

- **Syndromic Case Management (SCM):** For SCM, the WHO, NACO, and Avahan STI treatment guidelines as described in the COGS Guidelines for providing accurate diagnosis and complete treatment of STI to FSW, MSM were followed. In order to ensure drug compliance, directly observed single dose treatment was administered as per the guidelines using color coded packs.

- **Regular Monthly Check-ups:** Every KP is screened for STI through internal examination. Initial protocol was to mobilise KPs to the clinic once every month, during which each KP was motivated to undergo speculum or proctoscopic examination to identify asymptomatic infections.

- **Asymptomatic Treatment/Presumptive Treatment:** It was recommended that all KPs be given the treatment for gonorrhoea and chlamydia presumptively on their first visit if they do not have symptomatic STI on internal examination. The treatment was repeated every three months, if there were no STI symptoms or signs. Following IBBA first round results, the asymptomatic protocol was changed in 2007 to the first visit only and repeated only if the KP does not attend clinic for six months.

- **Syphilis Screening:** Syphilis screening was done once every six months for each KP attending the clinic and if reactive, immediate treatment was provided in the clinic. Initially syphilis screening was done through rapid plasma regain (RPR) test and later in 2007, a rapid test was implemented. Both RPR and ICST were carried out in Mythri clinics only.

- **Risk Reduction Counselling and Condom Promotion:** Risk reduction messages were reinforced at every point of contact: by ORW/PE on field, or by the staff at Mythri clinics. The clinic counseling was based on 4Cs of maintaining good sexual health (consistent condom use, compliance of treatment, contact tracing for partner treatment in case of STI, and counseling on STI/HIV). Promotion of correct and consistent condom use was done in the clinics by the counselors, ANM and the peer counselors.

- **Referrals:** The Mythri clinics worked as referral hubs. Referral linkages with existing government/private health care institutions were established for complicated STI, any other medical/surgical condition, TB, ART services and care support for those diagnosed with HIV.

- **Treatment for General Ailments:** Mythri clinics strategically provided treatment for simple general ailments like fever, headache, body aches, upper respiratory infections and diarrhoea.
etc. This definitely helped in rolling out the STI services as stigma attached to stand-alone STI clinics was reduced and the felt needs of KPs were being fulfilled.

- **Enhanced Syndromic Case Management (ESCM):** Latent syphilis is asymptomatic and can be diagnosed by simple blood test and treated completely with penicillin. Clinic based STAT laboratories were set up in six Mythri clinics in four intervention districts in 2005. The clinics were provided with basic equipment and a part time laboratory technician. Two day training was done on laboratory protocols for the ANMs, doctors and lab technicians covering blood collection through venipuncture, serum separation, RPR test procedure, result interpretation, treatment of syphilis, documentation, infection control systems, and external and internal quality control procedures. In 2006, ESCM was scaled up to ten other Mythri clinics and a total of 16 labs were established in 10 intervention areas. Of a total of 5,951 KPs tested, 1,110 were found to be reactive, with a reactivity rate of 18.6%. In 2007, the interventions were scaled up to 139 mandals and simultaneously, there was increase in coverage for STI services.

In 2006, ESCM was scaled up to ten other Mythri clinics and a total of 16 labs were established in 10 intervention areas. Of a total of 5,951 KPs tested, 1,110 were found to be reactive, with a reactivity rate of 18.6%. Following table shows the results of RPR tests done during 2006 and September 2007. Thereafter, Immunochromatography strip test was used for syphilis screening in Mythri clinics.

### Results of RPR Test (2006-2007)

<table>
<thead>
<tr>
<th>District</th>
<th>FSW Tested</th>
<th>Reactive</th>
<th>%</th>
<th>MSM Tested</th>
<th>Reactive</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anathapur</td>
<td>634</td>
<td>44</td>
<td>6.9</td>
<td>110</td>
<td>10</td>
<td>9.1</td>
</tr>
<tr>
<td>Kurnool</td>
<td>226</td>
<td>21</td>
<td>9.3</td>
<td>39</td>
<td>8</td>
<td>20.5</td>
</tr>
<tr>
<td>Karimnagar</td>
<td>605</td>
<td>329</td>
<td>54.4</td>
<td>418</td>
<td>189</td>
<td>45.2</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>565</td>
<td>69</td>
<td>12.2</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>NIRMAL</td>
<td>99</td>
<td>17</td>
<td>17.2</td>
<td>43</td>
<td>7</td>
<td>16.3</td>
</tr>
<tr>
<td>Chittoor</td>
<td>763</td>
<td>45</td>
<td>5.9</td>
<td>94</td>
<td>6</td>
<td>6.4</td>
</tr>
<tr>
<td>Khammam</td>
<td>1,346</td>
<td>287</td>
<td>21.3</td>
<td>32</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Warangal</td>
<td>182</td>
<td>2</td>
<td>1.1</td>
<td>539</td>
<td>36</td>
<td>6.7</td>
</tr>
<tr>
<td>Rangareddy</td>
<td>127</td>
<td>32</td>
<td>25.2</td>
<td>129</td>
<td>7</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,547</strong></td>
<td><strong>846</strong></td>
<td><strong>18.6</strong></td>
<td><strong>1,404</strong></td>
<td><strong>264</strong></td>
<td><strong>18.8</strong></td>
</tr>
</tbody>
</table>

### Quality Control for Rapid Plasma Reagin Test for Syphilis

**Internal Quality Control:** The internal quality controls consisted of

a. Conducting daily saline, negative and positive control using serum from earlier tested sample with known

b. Performing repeat test: Re-testing every fifth positive sample to validate the results and ensure reagents were working properly.
**External Quality Assurance System** was established with an external accredited clinical laboratory. The system consisted of the following:

a. **Validation of RPR results:** The Mythri clinic labs sent all serum samples that were found to be reactive for RPR and 10% negative samples to the external lab (Deccan Diagnostic in the first year but later to Regional STI lab at Osmania medical college, Hyderabad) along with their results. The samples were transported once a month maintaining cold chain. An arrangement with AP roadways transport was made for transporting the samples through bus courier. The sample was tested for reactivity in different dilutions. The reports were sent back to the NGO and Alliance India and discrepancy in result noted, if any. Results of 20 percent of RPR reactive samples were further confirmed using confirmatory TPHA test.

b. **External proficiency tests** were done once in a quarter. The Mythri lab technicians received two unknown samples which they tested for RPR and reported back to Regional STD Lab (RSL), Osmania Hospital. RSL then reported the laboratory specific performance to each lab and Alliance India.

c. **Lab Auditing:** Once a year, consultant from the external lab visited the laboratory and checked the systems as well as skills of the lab technicians.

There were refresher hands-on trainings for the lab technician organised in the external lab every year. Visit to the Mythri lab was made for on-site support if performance was poor and required skill building (as decided by the results of EQA and technical officer’s visit). The EQA results showed 98% specificity and 77% sensitivity.

All these labs tested for Hepatitis B surface antigen during first clinic visit as well as for pregnancy, if needed. Syphilis screening was done once every six months using RPR test. Additionally LE test was done on urine using multi reagent strips (also checking pH, sugar and proteins) as a marker for infection. Internal quality control procedures were put in place.

In 2007, the interventions were scaled up to 139 mandals and simultaneously there was an increase in coverage for STI services. Additionally, some more services were added to the essential sex worker package to ensure a more comprehensive package of services. With sustainability in mind, service delivery models services in scale up sites were provided through either public health care institutions (mostly PHCs), if such a facility existed within five kilometer radius. Otherwise, private doctors who were willing to provide STI services as per COGS were identified by the KPs themselves and linkages established with them for STI service delivery. All the doctors were trained on syndromic case management and clinic operating guidelines and systems.

**Additional Clinical Services**

- **Basic AIDS Care (2004-2008):** This was introduced to cater to the needs of PLHIV who were part of the programme. The doctors were given four day training on basics of HIV treatment and side effects, diagnosis and treatment of common opportunistic
infections (OIs), and care support services required for HIV positive individuals, including KPs. A resource book for doctors working in primary care setting was published.

- **TB Verbal Screening:** Starting in 2007, as part of intensified TB case finding, the PEs on the field would do a verbal screening of all KPs during their one to one contact, asking a set of questions that would help identify if a KP was suffering from TB. If suspected, KPs were referred to the Mythri clinic where they were again screened by the doctor and the TB suspects then referred to DMC for sputum test. If found positive on sputum examination, TB treatment was initiated through district TB unit and PE or Mythri clinic ensure complete treatment through regular follow up.

### Referrals from Mythri Clinics to RNTCP Diagnostic and DOT Centres

- **Verbal screening of all KPs for TB symptoms by PEs/ORWs in the field**
- **Verbal screening of all clinic attendees for TB symptoms at Mythri clinics**
- **Look For:**
  - Cough for 2 weeks
  - Fever and night sweats
  - Lymph node swelling (Neck/Axilla)
  - Unexplained weight loss
  - S/O meningeal irritation (headache, dizziness, neck rigidity)
- **Refer TB suspects to DMC (KP/sputum) for sputum test (2)**
- **Sputum negative**
- **Sputum positive for TB**
- **Pt TB treatment after categorisation**
- **DOTS Centre**
- **Mythri clinic**
- **A course of antibiotic and refer for appropriate investigation**
- **Follow up for compliance adherence to treatment**
The table below shows the trends of verbal screening for TB over the years.

**Table: Results of TB Screening Among KPs**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Indicator</th>
<th>Annual TB report from Alliance India CMIS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2008</td>
</tr>
<tr>
<td>1.</td>
<td>Number of KPs receiving at least one service from NGO per quarter</td>
<td>56,894</td>
</tr>
<tr>
<td>2.</td>
<td>Number of KPs referred to clinic by peers from field after verbal screening</td>
<td>12,250</td>
</tr>
<tr>
<td>3.</td>
<td>Number of KPs screened for TB in the clinic</td>
<td>50,522 (88.8%)</td>
</tr>
<tr>
<td>4.</td>
<td>Number of TB suspects referred to RNTCP unit</td>
<td>1,471 (2.9%)</td>
</tr>
<tr>
<td>5.</td>
<td>Number of TB suspects diagnosed with TB</td>
<td>106 (7.2%)</td>
</tr>
<tr>
<td>6.</td>
<td>Number of TB cases provided Treatment</td>
<td>88 (83%)</td>
</tr>
</tbody>
</table>

(Source: Alliance CMIS)

- **Syphilis Screening Through ICST:** Syphilis screening was initially being done through the labs established in some of the Mythri clinics using RPR test. However, there was lot of resistance from KPs to give venous blood sample and in one year, only 40% of the target population could be tested. In September 2007, point of care syphilis test (immunochromatography strip test) was introduced wherein the lab technicians and Mythri ANMs were trained on the test and test interpretation. The test was to administer, no special laboratory facilities were required and treatment could be initiated the same day. With introduction of this test, all the ANMs in Mythri clinics started screening the KPs for syphilis. Since the test can be performed through a drop of whole blood, it found easy acceptance with the KPs. Once this test was initiated, more than 80% of target population was tested for syphilis every year.

- **External Quality Assurance System:** Once a year, the ANMs collected venous blood at the time of conducting ICST and couriered the whole blood samples to an external accredited laboratory for validation along with their results. If the samples were discordant, the ANMs from the sites with discordant results was given refresher training on test procedure and another round of external proficiency was conducted six months later.

- **Changes in Protocols for Asymptomatic Treatment:** By 2007, the Integrated Behavioural and Biological Assessment (IBBA) study found out that gonorrhoea and chlamydia now existed amongst a very small population (<2% prevalence), and that frequent presumptive treatment given every three months was not advisable. The protocol for presumptive treatment was therefore revised and given only on first visit. It was repeated only if the KP did not come to the clinic for 6 months.

**Models of Service Delivery**

Alliance India improved service delivery models for FSW and MSM who needed services without stigmatisation and with confidentiality in easily accessible locations. Variety of service points were developed for key populations:
• **Static Clinics:** Static clinics were set up where there were more than 500 KPs. Each TI established a project owned clinic in their DIC or a site preferred by the KPs (keeping in mind accessibility of the place). The services were provided daily on fixed timings by a trained doctor. Laboratory services were established in these clinics.

• **Satellite Clinics:** In areas where the KP population was not high enough to have a doctor on all days, satellite clinics were established. The clinics were mostly organised in the DICs and were linked to the static clinic for drugs. The satellite clinics were conducted only on some days of the week, at particular times.

• **Mobile Clinics:** In areas that had scattered population and were difficult to access, mobile clinics were provided. The mobile clinics were fully equipped, and guidelines were established for them so as to ensure uniform quality of services in all the mobile clinics.

• **Outreach Clinics:** The outreach clinics were established in a place that the KP feels safe to access and is close to an area where KPs congregate, such as in brothels or in a KP’s house near the market area. The clinic team from the static clinic of that TI visited the place at a fixed interval (once a week or fortnight depending upon the number of KPs available) and provided the services to KPs who were mobilised there by the PE, thus maintaining the confidentiality of their identity.

• **Referral Clinics:** The KPs identified their preferred doctors from private clinics. The doctors were trained on essential sex worker package, syndromic case management and COGS. If needed, infrastructure support, such as examination light and speculums, was provided to these clinics. KPs were referred to this clinic on fixed days fixed times and the project nurse provided support to the doctor in examination and documentation. These clinics, also known as Preferred Provider clinics, were established in 2007 at the time of scale up in sites with low KP numbers (less than 250).

**Mythri Mainstreaming Model**

In 2007, as Alliance India scaled up to new sites, a conscious decision was taken to have alternate models of service delivery that could be sustained after the Avahan services were withdrawn.

Strategically, there was a need to start mainstreaming the STI services, but government services at that point were not acceptable to the KPs for many reasons. To overcome these issues, and generate demand for government STI services, linkages were established with government hospitals (PHC, CHC, district hospital) that were fully functional and the doctors at these centers were willing to provide STI treatment services to FSWs and MSM. The model used the government facility infrastructure and the government doctor, with the NGO placing its counselor and ANM for counseling, syphilis screening and documentation. NGO also provided the drugs, condoms and mobilised KPs to the clinic through peer outreach. Mythri mainstreaming model helped reach out to scattered populations in rural areas and in a study done by FHI, was found to be the most cost-effective model. The total number of STI clinics increased from 18 in 2004 to 156 clinics (static, outreach, MMM).
functioning in Telangana and Rayalseema regions of Andhra Pradesh. Whereas in 2006, static clinics were the predominant model of service delivery (66%), in 2010, referral clinics (MMM and preferred providers) constituted 53% of the clinics.

**Evolution of Mythri Clinics - Clinic Composition**

<table>
<thead>
<tr>
<th>Year</th>
<th>Static</th>
<th>Referral</th>
<th>Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>54 (66%)</td>
<td>28 (34%)</td>
<td></td>
</tr>
<tr>
<td>April 2010</td>
<td>61 (42%)</td>
<td>65 (53%)</td>
<td>6 (5%)</td>
</tr>
<tr>
<td>2009</td>
<td>61 (40%)</td>
<td>72 (48%)</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>61 (57%)</td>
<td>37 (35%)</td>
<td>8 (9%)</td>
</tr>
</tbody>
</table>

**Mythri Mainstreaming Model**

**UHC/PHC/AH**
1. KP friendly STI services
2. Delivery of essential sex worker package
3. Provision of free STI and OI drugs (supplied by NGO)
4. Quality standards (COGS) followed
5. Availability of doctor (from hospital and ANM)

**Provision of STI kits, basic equipments and**

**NGO led Mythri Center**
1. Peer outreach activities
2. Condom distribution
3. Peer led counselling
4. CBO formation
5. Advocacy
6. Supporting UHC/PHC in community mobilisation
Mobilisation of Community Members to Mythri Clinics

Demand for STI services was created through behavior change communication to the KPs by the outreach team during their regular visits. In the initial years, different NGOs have used different practices to increase patient flow to the Mythri clinics. Some of these strategies are mentioned below:

- **Making DIC a Place of Extra Learning and Fun:** Adult literacy classes (as most of our KPs were illiterate), Rangoli/Mehndi competitions, fashion shows were organised in the DIC to attract the community's interest and increase DIC attendance. In some cases, a video day was organised at regular intervals when popular films were screened on video.

- **Health Education Camps in Safe Spaces:** Awareness programs were organised for the community in safe spaces where Mythri doctor provided health education to the KPs. Peer educators promoted the camp as an educational activity where doctor would be available to answer their health related queries. In the awareness camp, apart from addressing their needs, the doctor also explained about STIs and provided STI services.

- **Performing Social Rituals in the DIC:** DIC was used as a platform for social gatherings for the community. The outreach workers and peer educators, along with their friends and MSM conducted “Dawath” (feast) and “Pushpavathy”, an initiation ceremony of one of the new entrants into the community. This social occasion was attended by a large number of KPs. The clinic team would be available on the premises to provide STI services to the KPs.

- **Outreach Clinics in Brothels:** Since brothel KPs have problems accessing the regular clinic due to lack of permission from the brothel owners and lack of time, outreach clinics were established in the brothels where clinical team goes once a week and provides STI and general treatment to the KPs.

- **Use of Government Health Care Premises for Mythri Services:** In a rural site of Kurnool district, KPs were not coming to the regular Mythri clinic as this was perceived to be “HIV-clinic”. To reduce the stigma attached to Mythri clinic, the NGO (Meriba) decided to have an outreach clinic in the local PHC once a week. This immediately improved the acceptability of the clinical services and KPs started reporting for STI check-ups.

- **SRH Integration:** Peer educators, outreach workers, counsellors and doctors in four sites were trained on reproductive health issues. The peer educators and outreach staff create awareness among the FSWs about menstrual hygiene, pregnancy care, family planning and STIs, and mobilised them to the clinic where specific counselling on reproductive health issues was provided in addition to STI services. Referrals were made for pregnancy care, delivery or abortion to local public hospitals and PPTCT centers where the linkages were already established.

- **Incentives to the KPs:** Any KP who reports to the clinic for regular monthly check-up for three consecutive months and undergoes internal examination was given a small gift like a make-up box. To increase the participation of FSWs, including secret sex workers, printed lottery tickets were distributed to all FSW by PEs and they were
Empowering Key Populations for Sustainable HIV Prevention

Incentives to the Best Outreach Team: Based on the number of one-to-one contact in the field and the number of KPs mobilised to the clinic by the team of peer educators and outreach worker, the best team was selected and given a prize.

Involving KPs in Clinic Management: In some places, the outreach health camps were completely managed by the CBO – they identified the space, mobilised the community to the clinic and organised the health camps. Outreach monitoring was also being done by the CBO. This included the mobilisation by the outreach staff to the clinic and tracking for follow-ups. Shadow project staff had been created in the CBO who were undertaking the duties of the normal project staffs. The CBO with the help of the project staff liaised with Indian Medical Association (IMA); as a result, IMA Doctors were part of the health camps.

Appointing Clinic Administrators: Every clinic had a clinic administrator appointed who ensured that Mythri clinics were KP-friendly, and monitored the quality of clinical services. S/he was the first person of contact for the KP in clinic and made the KP comfortable. The clinic administrator also conducted the exit interviews (client satisfaction survey) of the KPs who had attended the clinic and any problems experienced by the KP in terms of clinical service availability and accessibility and attitudes of the clinical staff was brought to the notice of the project management teams.

Providing additional Services: Treatment for general ailments, including the children and other family members as beneficiaries, helped increase attendance of the clinics. When KPs came in for general ailments, they were motivated to undergo internal examination for STI screening.

Clinical Services in Avahan Phase II (2009-2014)

The second phase of Avahan was about consolidating the gains made in prevention programming in the first phase and transferring the programme to the government in a phased manner. The second phase saw following changes:

Alignment with NACO Costing and Operational Guidelines: All TIs were aligned with NACO costing and operational guidelines to prepare projects for phased transition by April 2010. As per NACO guidelines, static clinics were only allowed if TI population was more than 800; the clinics could either have an ANM or a counsellor and there was no provision for laboratory technicians and clinic administrators; the costs of STI drugs and syphilis tests was reduced drastically.

Mainstreaming of STI Services: With Mythri Mainstreaming Model already in place in more than 50 mandals, KPs had already been accessing government healthcare facilities or private practitioners. However, in the first phase, these services were provided at a fixed time with support from project ANM and counsellor. In 2010, the KPs were asked to assess the services in regular OPD hours and the doctor’s
honorarium was withdrawn. The visits were recorded on the clinic attendance forms kept at the facility by the NGO. The clinic attendance forms were later collected from the facility by the ANM. Although all PHCs were now supplied with STI packs, the supply was erratic and supplemented by the NGOs. Linkages with Designated STI/RTI Centers (DSRCs) were established and KPs were motivated to avail STI services from these centers. Government doctors and nurses from PHC, CHC and district hospitals were trained on SCM of STI through regional faculty trained by SACS. The activity was undertaken in coordination with APSACS and NRHM. More than 500 doctors and staff nurses were given a three day training in seven districts of Rayalseema and Telengana.

- Integration of HIV and SRH Services for FSW: Recognising the need of the female sex workers for comprehensive sexual and reproductive health services, a pilot project was initiated in four Mythri clinics. Communication and referral services to address other sexual and reproductive health needs of the sex workers were also integrated with STI services, thus expanding the scope of services. Information on menstrual and personal hygiene, family planning, safe abortion, pregnancy care, and cervical cancer screening through pap smear was provided to FSW through ORWs who were trained on these issues. The messages were reinforced in the clinic by ANM and doctor and appropriate referrals for services were made. The clinics also distributed free oral pills, procured from family welfare unit of district hospitals. In 2011, the PEs of all TIs were trained on messages related to SRH through a district resource pool to educate during their one-to-one contact with FSW. Linkages have been created with government facilities where KPs requiring SRH services are referred to.

- Care and Support Integration: Based on the START-AP experience (see below), care and support was integrated in HIV prevention services in 2010. A community liaison officer was recruited for each ART center to create enabling environment for treatment access. At TI level, a positive peer was trained to provide information and counselling to all KPs found to be positive. S/he was also responsible for motivating

Reach of HIV and SRH Integrated Services

<table>
<thead>
<tr>
<th>At Field Level</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group sessions/one to one sessions</td>
<td></td>
</tr>
<tr>
<td>Menstrual Hygiene/Family Planning/ANC</td>
<td>1,371/2,100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Clinic Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of pregnant women reported to the clinic</td>
<td>39/1,132</td>
</tr>
<tr>
<td>Number of women given FP counselling</td>
<td>36/1,132</td>
</tr>
<tr>
<td>Number of women with high risk pregnancy</td>
<td>9/39</td>
</tr>
<tr>
<td>Number of pregnant women reporting to clinic with STI</td>
<td>12/39</td>
</tr>
<tr>
<td>Number of pregnant women undergoing pap smear</td>
<td>32/600</td>
</tr>
<tr>
<td>Number of women given oral contraceptives</td>
<td>17/600</td>
</tr>
<tr>
<td>Number of women referred for ANC</td>
<td>35/39</td>
</tr>
<tr>
<td>Number of women referred for abortion</td>
<td>4/39</td>
</tr>
<tr>
<td>Number of women referred for PPTCT</td>
<td>26/39</td>
</tr>
<tr>
<td>Number of pregnant women found HIV Positive</td>
<td>7/26</td>
</tr>
<tr>
<td>Number of HIV women who had institutional delivery</td>
<td>3/3</td>
</tr>
</tbody>
</table>
In 2007, a pilot project was introduced in Karimnagar district in collaboration with APSACS to strengthen the ART services for the PLHIV. Infrastructure support to the ART center and additional human resources (community liaison officer to facilitate the PLHIV access to hospital services, laboratory technician, and coordinator for APSACS) were provided by Alliance India. Demand generation for ART services was taken up by the TI NGOs who recruited positive peers to mobilise and support tracking and follow-up to ART services. Support groups were formed and coordination between NGO, Alliance India, district health officials and APSACS was increased. The project resulted in increase of not only the number of KPs diagnosed with HIV, but also those registered with ART centers, and ART adherence improved.

Encouraged by these results, the initiative was scaled up to three districts (Karimnagar, Warangal and Khammam) in 2009 with some modifications as by then ART centers had been scaled up in the country by NACO and infrastructure support was no longer required. The results clearly showed that with minimal inputs and cost, it is possible to provide the HRGs with comprehensive ART services linked to prevention services. Moreover, this is the first time that such statistics and data on KPs accessing ART services was available for high risk population in any district.
Graph 1: ICTC referral and HIV testing among HRGs in districts of Karimnagar, Khammam and Warangal in AP during project period (2009)

HIV Testing & Positivity

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Mar-09</th>
<th>Dec-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral for HIV test</td>
<td>4,420</td>
<td>21,442</td>
</tr>
<tr>
<td>HIV Tested</td>
<td>3,106</td>
<td>18,271</td>
</tr>
<tr>
<td>HRG Tested +ve</td>
<td>952</td>
<td>1,550</td>
</tr>
</tbody>
</table>

Graph 2: Uptake of ART services in the districts of Karimnagar, Khammam and Warangal

Access to ART services

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Mar-09</th>
<th>Dec-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRG tested +ve</td>
<td>952</td>
<td>1,550</td>
</tr>
<tr>
<td>Referral to ART Centre</td>
<td>583</td>
<td>1,296</td>
</tr>
<tr>
<td>Pre ART registered</td>
<td>340</td>
<td>1,111</td>
</tr>
<tr>
<td>HRG PLHA on ART</td>
<td>126</td>
<td>410</td>
</tr>
</tbody>
</table>
Capacity Building for Clinical Services

The capacity building for clinic staff involved central workshops, manuals and guidelines development and on-site technical support and mentoring by the Alliance India technical team.

- Doctors were trained on SCM protocols, STIs among KPs, sex and sexuality, sensitivity towards KPs, STI and counselling issues among MSM and TG, primary HIV care, COGS, and documentation of case on clinic attendance forms. In general, two training programs were held each year, one for the new staff (three day duration) and one refresher training (two days).
- Two-day workshops were held for nurses on STI/HIV basics, STI management and counselling, COGS, infection control, anaphylaxis management, drug stock maintenance and procurement systems, clinic documentation and reporting. One day refresher training was also organised every year.
- Counsellors were trained on sex sexuality, STI/HIV issues, STI management, risk reduction counselling, communication skills, pre and post-test HIV counselling. Five day workshops were organised every year initially and later, refreshers for three days.
- Two day training workshop was organised for lab technicians for training on blood sample collection, storage and transport, serum separation, RPR, hepatitis-B and pregnancy testing techniques, internal and external quality control systems, infection control system, and documentation.
- Peer counsellors trained on basic counselling skills and health education to support the ANM in counselling and providing health education during the clinic hours. PE/ORW and ANMs were trained on verbal screening of TB; an MPW module was used in a half day to about 2,000 participants.
- Clinic administrators were trained on how to monitor the clinics, conducting exit interviews and participate in clinic services review committee, and documenting the basic information on each KP in KP registration form.
- ANMs along with the district network members were trained on SRH and care and support for PLHIV, who then trained the PEs to address the SRH needs of the FSW and care support needs of positive KPs by delivering the key messages in the field.

Good Practices

- Colour coded STI packs for treatment of symptomatic and asymptomatic STIs have been adopted nationally by NACO.
- Point of care rapid test for syphilis screening (ICST) replacing RPR ensured easy acceptance of the test by the community. Once this test was introduced, more than 80% of the target population was screened every year. The test was cost-effective, reliable and results available immediately allowing for the treatment to be given in the same visit.
- STI Mapping to ensure saturated coverage of KPs with services. All hotspots were mapped along with total population of KPs, the number of KPs who have accessed clinical services and distance from the clinic. Hotspot level meetings were organised by the project staff for places from where KPs had not attended the clinic and reasons
for not attending the clinic were discussed along with possible solutions. If distance was an issue, preferred provider near the hot-spot was selected for providing the services. In a few cases, timings were an issue and KPs preferred to have a night clinic, e.g., Tirupathi and Warangal. The medical officer provided weekly services at the hotspot in a safe space from 7 pm to 9 pm.

- Integrating HIV with SRH to provide a spectrum of services to the KPs as a one-stop-shop model is essential. Evidence indicates that sexual and reproductive health (SRH) needs, such as information on contraception, menstrual hygiene, safe abortions as well as service availability, are un-met. Hence, vulnerability to HIV increases among sex workers. Mythri STI clinics or Suraksha STI Clinics provided a platform for integrating SRH services with existing HIV/STI services.

Materials and manuals developed for clinical services are listed in chapter 8.
Chapter 5

Community Mobilisation and Advocacy

Individual risk behaviours are influenced and determined by the broad social and economic environments and structures within which they take place, and which they are powerless to control. Unless the social forces and structures that influence community action and individual behaviour are understood, identified and changed, targeting individuals with information and services alone will be limited in impact. Creation of enabling environment is necessary for reducing social marginalisation and vulnerability of the KPs to HIV and increasing access to health services and their rights. Community mobilisation (CM) and community-led structural intervention (CLSI) are critical components of enabling environment and, therefore, community participation and mobilisation were vital part of Alliance India interventions right from the inception of the programme.
**Community Mobilisation and Structural Interventions:** Structural interventions constitute developing specific strategies and action to change/modify existing social structures/bodies of control and policies in favour of the marginalised through a process that is led by the vulnerable groups themselves. These interventions when implemented in partnership with the community is Community Led Structural Interventions (CLSI). This happens through various processes of active participation and ownership building wherein the community gets mobilised and empowered by changing existing power relations at all levels, creating an enabling environment for behaviour change and community action. CLSI has three important components:

- Mobilising community though active participation and rights based work.
- Ensuring access to and utilisation of services.
- Building an enabling environment for behaviour change.

Community mobilisation is a process through which community members pass through following stages: (a) become aware of a problem, (b) identify the problem as a high priority for community action, and (c) decide on steps and take action. Community participation is essential for members to gain ownership. Active participation of the community not only makes a development project more sustainable but also provides protection to the community members from vested interests, gives dignity and self-reliance, enhances sense of value and worth, and instead of being passive receivers they become active participants. Moreover, the community members can understand the local needs better and can become effective health educators with good training, and can be the agents of change. Though the process of community participation seems a slow process at the start, later the multiplier effect causes a rapid increase in growth.
Steps in community mobilisation include:
- Building trust and confidence.
- Addressing issues of low self esteem.
- Making an invisible community ‘visible’.
- Creating ‘space’ within the management of the program.
- Putting sex workers at the centre stage of the program.
- Inculcate community empowering processes.
- Addressing perceived needs of the community.
- Addressing the issue of stigma attached to sex and sex-work.
- Community Mobilisation Strategy.

A strategy paper on community mobilisation detailing the approach to community mobilisation in AP was developed in 2004. The approach was based on Alliance India’s global experience and global best practices. Key elements of the strategy included the following:

**Participatory Site Assessment**

Building on the gains made in FPP, PSA was to be extended to all sites with the purpose of identifying HIV-related needs, facilitating site and population specific intervention design with KP members, and beginning the process of mobilising key population groups for HIV/STI prevention through identification of vulnerability factors and taking suggestions from the community for risk reduction strategies.

**Action at the Community Level**

- Involving KPs in project planning from the beginning and developing their self-esteem.
- Promoting self-esteem and awareness and developing a shared understanding on vulnerability to STD/HIV.
- Enabling and supporting individuals and communities to communicate, negotiate, advocate and push for change with gate keepers and other bodies of control within and outside their communities.
- Facilitating the KPs in getting bank accounts and other social entitlements.
- Facilitating formation of CBOs.
- Facilitating network formation of FSW, MSM and PLHA and linking them with other such collectives across India for cross-learning and sharing.

**Action at the Structural Level**

- Formation of committees at project level with KPs, including project advisory and monitoring committee, advocacy committee and an IEC committee.
- Employing KPs as staff members of NGOs at supervisory role, not just as peer educators.
- Developing community level organisations.
- Developing a code of conduct for NGOs covering issues of discrimination, stigma and denial, democratic functioning, respect, recognition, and reliance.
- Participation of KP representatives in annual programme reviews.
Implementation of CM and CLSI

In Alliance India’s interventions, community participation began with the process of participatory site assessment, and strengthened through increasing share of responsibility given to the community members for various project activities over the next few years. This included recruiting outreach teams and other project personnel from the key populations, establishing community monitoring mechanisms, collectivisation at hotspot level forming community based groups which were given responsibility to manage DIC, DIC based events, clinics and advocacy, and finally having formal community based organisations running the TIs or working to reduce vulnerabilities to HIV.

2004-2006

The community participatory approaches included:

- **Participatory Site Assessment (PSA):** This process was used not only as a method for estimating numbers to inform site selection, project design and resource allocation levels in each site, but also as an intervention to mobilise the key populations. In first phase, while identifying the subgroups of key populations, peer facilitators worked to identify the context of HIV/STI risk and vulnerabilities. In phase two, half-day participatory workshops were held with different key population subgroups. At these workshops, vulnerability factors and risk behaviour were further explored, and suggestions for how the interventions could best be implemented in each site were discussed. Participants also shared ideas for safe sex techniques and other risk reduction strategies. During this process, six key population representatives were provided two week-long training courses on STI/HIV/AIDS and the use of participatory tools. At the end of the process, representative from each of the communities of FSW, MSM, IDUs, and PLHAs were selected and trained to further facilitate community mobilisation and social capital building, create safe spaces for the communities, increase awareness on STI/HIV, promote condom use, and refer individuals to key population-friendly STI clinicians in the locality.

- **Engaging Community Members:** The community members with good communication skills and wanting to be part of community action were taken as outreach workers who were full time staff. Active involvement of the community at each level helped increase confidence of the community, their ownership of project and built in a strong desire for community action. The skilled KPs were given increasingly higher roles and responsibilities and advanced from being ORW to clinic administrators, counsellors, MIS officers, Assistant Project Coordinator (APC) to Project coordinators (PC). The KPs were actively involved in proposal development of the NGOs and an MSM and an FSW representative of NGOs participated in the proposal development workshops. Based on their suggestion and to facilitate their participation, annual and half-yearly reviews were later organised at district levels.

- **Monitoring Committees** were constituted to monitor project activities and clinical services. These committees had at least three community members as members and were convened by the community members. These committees included Project Advisory Committee (PAC) and Clinic Service Review Committee (CSRC).
  - **Project Advisory Committee** for each implementing NGO partner was established
to strengthen the overall project management and enhance their resource base. PAC members included project staff, community members and local eminent persons from government, non-government and professional organisations who can support the project activities and address/advice on the sexual as well as nonsexual needs of the community. The committee met once a quarter to review the activities, identify needs and suggest steps to address the meets.

- **Clinic Services Review Committee** was established to ensure that clinical services are accessible, efficient, effective and KP friendly. The committee was convened by the clinical administrator and other members included representatives of the community from the site and outreach team. The clinic doctor and project director attended, if invited. The committee met once in a quarter and reviewed KP satisfaction with clinical and counselling services and recommended improvements on the existing service quality to the project director or project coordinator.

- **Clinic Administrator**: Clinic Administrator, a community representative, appointed to ensure KP-friendly services from the STI clinic, kept a check on the clinic equipment, drugs and supplies through checklist and by regularly doing satisfaction surveys. Satisfaction surveys (exit interviews) were conducted on every fourth KP attending the clinic and results were compiled at end of month and presented in monthly meeting to project staff. Serious issues were also brought to the notice of clinic service review committee and appropriate action was then taken. Based on the exit interviews, corrective action was taken in many sites, especially in the first phase. This included changing the timings or location of the clinic. In a few instances, the medical officers were also changed, mostly because of lack of sensitivity towards KP issues.

- **Community Representation**: Community representatives were part of the annual review and proposal development at the project level. The KPs were actively involved in proposal development of the NGOs and one MSM and one FSW representative of NGOs participated in the proposal development workshops. Based on their suggestion and to facilitate their participation, annual and half-yearly reviews were later organised at district levels. Community response fund was also the community’s idea.

**Community Mobilisation Initiatives**  
**Micro Level:**

- A code of conduct was developed and shared with NGOs that covered issues around discrimination, stigma and denial, democratic functioning, principle of 3-Rs, i.e., respect (for the communities treating them as their equals), recognition (of the communities profession, needs, priorities, aspirations) and reliance (on the communities abilities, encouraging them to take key project decisions), and being non-judgmental.
- Each DIC displayed the rights of KPs.
- DIC meetings were organised to create awareness and develop shared understanding of KPs on vulnerability to STI/HIV and workshops were organised on legal literacy. NGOs put efforts in occupational skills building – computer classes, beautician courses, adult literacy classes, phenyl-making etc.
Many NGOs linked up the community members with district administration’s income generation activities. The PLHIV CBO of GNNS, Karimnagar (FPP) was one of the very active CBOs supporting its members through sale of home-made products like phenyl and jute bags – a fact noted by the print media. The formation and registration of community groups, community based organisations and formal networks was facilitated by the NGOs.

NGOs also facilitated the acquisition of bank accounts and other social entitlements.

Alliance India supported the community groups in developing linkages/affiliation with sex workers/MSM/PLHA collectives and movements across India in order to learn from their experience. Exposure visits were organised to DMSC Bengal for sex workers and to Hum-Safar Trust, Mumbai for the MSM for cross-learning.

Formation of Community Based Groups: Active participation of KPs in project activities and collectivisation by the TSS and outreach workers resulted in community groups coming together for action. In FPP sites, LEPRA was responsible for community mobilisation until mid-2005 and by that time about 60 CBGs were formed. The structure of these groups varied, most of these being site level groups. These groups were mostly working on the issues of violence by the police or clients, and denial of services (health or non-health related) due to HIV stigma and discrimination by service providers. The collective action not only helped reduce feelings of social isolation but also strengthened their capacity to effectively address health issues, as well as issues of stigma, denial, rights, and access to services at the local level.

Formation of CBOs: Efforts were made to help some of these newly established groups to evolve into local organisation or institutions that continue to work on HIV/AIDS. Registration process of CBO was initiated in few sites by holding workshops for developing vision, mission and by-laws for each organisation. Fourteen TI-Level FSW CBOs and eight...
MSM CBOs were formed in 2005. In addition, a state level sex worker network, Mythri Mahila Sangham, was also formed in Chittoor district. The registered CBOs performed various functions such as managing DIC, organising group meetings and DIC events, police sensitisation, resource mobilisation for the PLHIV, monitoring outreach workers’ performance, and in some cases, managing the entire outreach component of the project. Following trainings of CBO members on media handling, advocacy, and legal literacy, they started playing more active role in local advocacy activities as part of crisis response teams and core advocacy groups. The capacities of CBO on project management, financial management and systems, organisational development, and legal and ethical issues was strengthened by CARE and DMSO. The executive committee members of CBOs, Mythri Mahila Sangam and District coordination committee members were also trained on leadership development.

- Community Response Fund: The fund was initiated on the request made by community representatives during the proposal development workshops. Around 2.5 percent of TI annual budget was included in all the NGO grants to address the emerging needs of community regarding vulnerability reduction of KPs. The needs identified were nutrition support, help with harassment, banking/saving, child care and education, etc. Community decided the priorities and a monitoring plan was

Best Practice

Swayam Shakthi Social Welfare Sociey (MSM CBO, Mancheriyal)

Shadow Team
At Mancheriyal, under the guidance of NGO AIRTDS, a MSM CBO, sangham, was formed in 2005 which was registered under AP Society act, 2001. Regular meetings were organised as per the by-laws of organisation to chart out their activities. They appointed shadow staff of CBO (Blue print of an NGO on CBO) to develop the understanding and capacity for programme management of their members. The skills o shaw staff were built in the following areas:

Shadowing helped them in building communication, networking, decision making, administrative and accounting skills. They visited other CBOs and NGOs for exposure.

Monthly activities
1. Condom procurement from DLO office Adilabad and social marketing of Mythri condoms on monthly basis
2. Fruits distribution to PLHAs at care & support centre at Bheemaram
3. Promoting enterprise through knitting sari, embroidering and tailoring
4. Liason with police people, local doctors, ICTC and Area Hospital Mancherial
5. Monthly meetings with madams, pims and billas at hotspot wise
6. DIC maintenance, field visits for the improvement of mythri clinic
7. CBO members conducting group meeting with the KPs
8. CBO members getting training on counselling
9. Monthly sessions by counselor on STI/HIV to he members & CBO KPs
10. Referrels to PLHA KP to Bheemaram (care and support centre)
11. CBO members’ enrolment and identification of new KPs

Shadow team of the CBO participated actively to ensure achieving the set milestones by the project. They acted as bridge between the hotspot level community members and brought their problems of access to the notice of the NGO. New STI clinics were initiated in safe places. In addition, they were instrumental in organising awareness camps, STI camps, sorting out water shortage problems at two hot-spots, addressing violence through Rapid action teams and mobilising community for ‘Red Ribbon Express’.
established to assess fund utilisation, and acceptability to the community. The fund was managed by the CBOs with support from TI NGOs.

- **Community Participation and Ownership** was discussed with NGOs regarding transferring of some if not full project activities to the natural owners, i.e., the communities and CBOs. The capacities of CBO on project management, financial management and systems, organisational development, and legal and ethical issues was strengthened by CARE and DMSO. The executive committee members of CBOs, Mythri Mahila Sangam and District coordination committee members were also trained on leadership development.

- **Shadow Teams**: CBO members were recruited as shadow members to the NGO teams, an initiative started by AIRTDS in Mancheriyal. The concept was supported and extended to all the implementing NGOs by Alliance India. By the end of 2007, all NGOs had shadow teams and gave varying responsibilities for project activities to the CBO members.

The CBO formation remained slow in the second half of first phase. However by 2006, understanding the importance of strengthening community initiatives and institutions for sustaining the HIV prevention efforts at community level, BMGF themselves changed their position and decided to focus on strengthening community mobilisation and CBO formation.

**Evolution of CBOs**

By 2008, there were 115 CBOs (67 registered and 48 unregistered) with membership of 24349 KPs (35.4% of total registered population), one regional and two district level MSM networks and a state level FSW network. Under each TI, there was a FSW and MSM CBO. The CBOs were given trainings on governance as well as leadership, and CBOs were given responsibilities for BCC and promoting outreach, site level response to crisis and advocacy initiatives, managing Mythri clinics and DIC, or mobilising the community for HIV testing.

**Number of community groups formed**

<table>
<thead>
<tr>
<th>S No</th>
<th>Year</th>
<th>No of Districts</th>
<th>No of community groups/ unregistered CBOs</th>
<th>Registered CBOs</th>
<th>Total CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MSM</td>
<td>FSW</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>June 2005</td>
<td>9</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Dec 2005</td>
<td>13</td>
<td>38</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>Dec 2006</td>
<td>13</td>
<td>42</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>Dec 2007</td>
<td>14</td>
<td>53</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>Dec 2008</td>
<td>14</td>
<td>48</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Jun 2010</td>
<td>13</td>
<td>31</td>
<td>32</td>
<td>20</td>
</tr>
<tr>
<td>7</td>
<td>Dec 2011</td>
<td>8</td>
<td>37</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Dec 2012</td>
<td>8</td>
<td>CBGs</td>
<td>19</td>
<td>22</td>
</tr>
</tbody>
</table>
During Avahan Phase II, there was merging of more site level groups and by June 2010, there were 46 FSW, 37 MSM CBO and 13 District networks were there. Of these, 52 CBO were registered under AP Society Act 2001. By next year, the number of registered CBOs increased to 59 CBOs (37 FSW and 22 MSM). For 2012-13, the CBOs have been restructured and currently 42 FSW CBOs have restructured to form 19 FSW CBOs. In addition small groups of about 15 KPs led by a facilitator have been formed.

**Service Quality Dialogue Tool:** To scale up community ownership and mobilisation, Avahan developed ‘Service Quality Dialogue Tool’, a tool that used the process of discussion, measurement and planning for enhanced community ownership through participatory approach. The tool was to be used at all intervention sites by programme team of SLPs and NGOs. Training to Alliance India team was provided by CARE, capacity building partner of Avahan in this thematic area, and Alliance India then trained their NGO functionaries. The goal of the dialogue process was to analyse the programme, not to rate it, and determine the areas that require more efforts for improving them. The tool was used every six months.

**Evolution of CBOs**

The CBO formation remained slow in the second half of the first phase of Avahan. However by 2006, understanding the importance of strengthening community initiatives and institutions for sustaining the HIV prevention efforts at community level, BMGF changed its position and decided to focus on strengthening community mobilisation and CBO formation. By 2008, there were 115 CBOs (67 registered and 48 unregistered) with membership of 24,349 KPs (35.4% of total registered population), one regional and two district level MSM networks, and a state level FSW network. Under each TI, there was an FSW and an MSM CBO. The CBOs were given trainings on governance as well as leadership, and CBOs were given responsibilities for BCC and promoting outreach, site level response to crisis and advocacy initiatives, managing Mythri clinics and DIC, and mobilising the community for HIV testing. During Avahan Phase II, there was merging of more site level groups and by June 2010, there were 46 FSW and 37 MSM CBOs and 13 District networks. Of these, 52 CBOs were registered under AP Society Act 2001. In a year, the number of registered CBOs increased to 59 CBOs (37 FSW and 22 MSM). For 2012-13, 42 FSW CBOs were restructured to form 19 FSW CBOs. In addition, small groups of about 15 KPs led by a facilitator were formed.

**CBO Committees:** CARE, capacity building partner of Avahan conducted trainings of the CBOs on organisational development and TI program management. Each CBO had a committee for each TI component (outreach, DIC, condom, clinical, advocacy, and resource mobilisation). The CBOs were managing the DIC activities, advocacy at the local level, income generation activities, organising awareness meetings and events, and in some cases, managing the entire outreach component.

**CBO Evaluations:** In 2009, Mithra and TNS Mode conducted CBO evaluations in the twelve districts. Administering the PRAXIS tool, each CBO was evaluated by a team of two investigators on the parameters of leadership, governance, decision making, resource
mobilisation, community networks, project risk management, engagement with state and larger society, advocacy, and lobbying. Based on this assessment in 12 districts with 92 CBOs, 15 CBOs were rated as Promising I, 51 as Promising II, 22 CBOs as Promising III and four CBOs were ranked as Foundation. Based on the learnings from the CBO assessment conducted by PRAXIS, a simplified tool was developed on five parameters – governance and leadership, project management structures, resource mobilisation, financial management systems, and engagement with state and other key stakeholders.

**District Level Networks:** By the end of 2009, there were more than 100 CBOs in the intervention sites. To bring them together, district level network formations for FSW and MSM/TG was facilitated by the Alliance India programme team. In Chittoor, district networks were formed in 2006; Mana Mahila Sangam for FSW and Nava Samajam for MSM were registered under Andhra Pradesh Societies Registration Act, 2001. These were revived in 2010 and also registered under section 12A and 80G of Income Tax Act. The district networks were formed in 2010 with the objective of strengthening community mobilisation. The networks were registered under AP Company Act, 2001. Intense capacity building was taken up by Alliance India for the district networks in 2010 which included trainings on leadership, governance, finance management and resource management; exposure visits were conducted to learning sites in Ashodaya Mysore, DMSC Sonagachi and CARE Rajmundry. In 2011, Alliance India entered in a service contract with the district networks.

**District Network Coordinator** was responsible for coordinating network activities and supporting the CBOs at TI level. S/he was responsible for coordinating all district network activities, supporting the CBO Associates within the district, coordinating all the district level HIV events and documenting of all meeting minutes.

**District Level Task Committees:** The coordinator was supported in his/her work by many
District Network Structure

- Programme Management Committee with primary function of providing supportive supervision to the TI level CBO. They participated in the monthly TI review and provided inputs to the TI and CBO. The committee ensured cross-learning between CBOs of the district, thus resulting in enhanced understanding and strengthening of CBOs.

- Advocacy Committee with crucial role in advocating for the rights of the community and facilitating the process of mainstreaming. This committee was also responsible for supervising the advocacy committee at CBO TI level (primarily responsible for crisis management in coordination with CAT and CAG members) and to develop community spokespersons.

- Resource Mobilisation Committee to mobilise resources for sustenance of community initiatives, facilitate the promotion of individual skill development on income generating activities and ensure linkage of CBO for the entitlements at the district level. In 2011, five district networks submitted proposals to Rajiv Vidya Mission for resource mobilisation.

Restructuring of CBOs: In consultation with SACS/TSU and BMGF, eight districts were chosen for implementing CM program from April 2012 to December 2013. The districts include Anantapur, Chittoor, Nalgonda, Karimnagar, Khammam, Nizamabad, Adilabad and Warangal. A self-assessment of CBOs was done with the abridged version of the PRAXIS tool and based on weighted score CBOs were categorised. A detailed work plan was developed following consultation with FSW and MSM CBOs office bearers. A total of 59 CBOs (37 FSW and 22 MSM) are being capacitated during 2012-2013. The institutional...
structure of CBO related to its size, strategy, governance and executive systems was redefined, focusing on community action for tackling HIV issue in the community. The new structure ensured complete involvement of the community. Merging of CBOs was done based upon the geography, accessibility, and revenue and administrative division and also on CBO willingness and views of parent NGOs. Four FSW CBOs implementing the TI programme with the support of APSACS were merged into one, thus ensuring TI management continued with the pre-existing CBOs. Overall, 42 FSW CBOs have been restructured into 19 CBOs in eight districts.

Social Marketing Organisation (SMO): In an effort to rollout of condom promotion by TIs, Alliance India organised a two day community consultation to develop strategy for strengthening systems of community involvement in the prevention efforts. Based on the community consultation discussions, one of the major constraints identified was lack of community ownership and involvement in the condom promotion/programming. As an outcome of the consultation, Mana Mahila Sangham (FSW district network) and Nava Samajam (MSM district network) from Chittoor district together went ahead to establish an SMO office at Piler with technical support from Alliance India, to promote social marketing of condoms and lubricants. The combined network was known as Mythri Mithra and MoU was signed between Mythri Mithra and Alliance India in May 2010.

Development of Learning Sites: By 2010, the CBOs had good understanding of the need for collectivisation and were organising structured activities for increasing membership, providing support to the communities for better access to social entitlements, and strengthening crisis response systems. There emerged a need to share these good practices and cross learning between CBOs and NGOs. Therefore, learning sites were developed across Avahan to institutionalise sustainable community driven learning systems in TI. The overall goal of learning sites was in creating community to community cross learning systems by enhancing capacities of TI NGOs and CBOs to apply effective CM strategies for TI management and strengthen a network of APSACS, TIs, NGOs, and SLPs. Successful interventions with community engagement in management of TI program and with sufficient evidences to show impact on overall TI core indicators were selected for cross-learning by other CBOs and NGOs. Learning sites selection was done by CARE through external evaluation of CBOs and Jhansi Laxmi CBO of Anantpur and Prema Sangam Mahila Mandali, Chittoor were selected in June 2010 for further nurturing and facilitation of cross learning. The NGOs affiliated with the CBOs were CERA Anantapur and PASS Chittoor respectively. In 2011, Vanitha Mythri Public Welfare Society (VMPWS), Karimnagar was also selected for implementing the learning site initiative.

CBO-led TIs: In 2009, Praxis, an Avahan partner for building communities, carried out an assessment of CBOs and identified promising and vibrant organisations that could be further strengthened to manage TIs. Following seven CBOs were considered for TI management by Praxis: Liberty to Individual’s Fundamental Efforts, Nalgonda; VMPWS, Karimnagar; Pragathi Mythri Mahila Sangam, Guntakal; Shakti Mythri Mahila Sangam,
Community Resource Mapping (CRM): The Community Resource Mapping (CRM) exercise was initiated with the support of Avahan in Warangal district. The purpose of CRM was to identify resources by the community members to address their needs, getting into agreements with the service providers for accessing the services, and finally managing the resources through self-governance. The community members completed the resource mapping following participatory methodologies. This exercise helped the community members to understand the equity, setting up conflict resolution and monitoring mechanism in accessing the resources.

Community Solidarity Events

- **AP Sex Worker Convention:** A three day state convention of sex workers was held in Hyderabad in November 2006. All organisations working on the HIV prevention in AP participated and was facilitated by DMSC. The participants consisted of 2500 FSW, MSM and TGs from all intervention areas. The activities during these three days included panel discussions, debates, presentations from KPs and cultural events in evenings. Media interactions were planned to highlight the issues of KPs.
- **Swetcha Sammelan:** Sex Worker convention became an annual feature after 2006 and is being led by APSACS. Every year, the sex workers gather in Hyderabad to bring attention of state authorities to their plight, with suggestions to improve the quality their life through policies on violence reduction. The day is also marked by day long cultural events.
- **Melukolupu:** Events similar to Swetch Sammelan were celebrated for the MSM as well every year at the state level.
- **Knowledge Olympics:** This was an activity initiated by Avahan to promote cross sharing and learning among various state lead partners across the six states of Avahan interventions. Through Knowledge Olympics communities were expected to take charge to lead, connect and change to improve their lives.

Solidarity events were organised at Chittoor, Nalgonda, Khammam, Ananthapur and Medak by involving all district collectors and the line departments to help increase access to social welfare schemes. During these meets, community members interfaced with all the district officials and explained to them the social and economic vulnerability and the need for increased access to welfare schemes. The community solidarity events were organised collectively by FSW and MSM District Networks.

Creation of Enabling Environment

The unsupportive, discriminatory and at times even punitive nature of the policies and laws related to the key populations is counter-productive to HIV prevention efforts. Frequent police raids on sex workers and unwarranted arrests by the police for carrying condoms or for homosexuality drive the KPs underground and make it difficult to sustain
HIV prevention activities. Several case studies and results of research studies published by various organisations show high levels of state led and institutionalised violence that affect the KP’s ability to negotiate and engage in safer sexual practices. The need for action directed at changing the policies, raising the public profile of a problem building support to tackle the problem was therefore obvious.

**Issues of Violence, Stigma and Discrimination**

The issues identified included the following:

- Institutional violence: verbal/physical/ssexual abuse/extortion of money/illegal arrests or detention by the local police and physical/sexual or monetary abuse by pimps and madams.
- Intimate personal violence: physical/sexual abuse/coercion/extortion of money by clients/partners/spouses/local goons.
- Social violence: stigma/discrimination/marginalisation by service providers and denial of services; discrimination by family and community.
- Economic exploitation: by clients/partners/local money lenders/pimps/madams.
- Lack of availability/consistency in supply of health information, condoms, lubricants, drugs.
- Lack of access to AIDS treatment and basic AIDS Care.
- Refusal to use condoms by clients/partners and lack of negotiation with sexual partner.

**Alliance India Advocacy Strategy**

A strategic plan for advocacy initiative at district and sub-district level was defined with the purpose of advocating with the government for policies that protect the KPs from coercion, violence and other forms of abuse and promote access to economic and social services, and with civil society organisations for policies that empower the KPs. The advocacy work was to be led by the KPs themselves with the support of local NGOs and Alliance India staff.

Clear advocacy messages were developed on identified issues/problem and delivered to the decision maker along with recommendations for its solution. The message could be delivered personally in a meeting with the decision maker or in workshops; public interest and support could be generated through posters, banners, fact sheets, newspaper columns, newsletters, or radio and television announcements etc., applying pressure to gain support from the policy makers.

Action plan was prepared for each NGO specifying the problem, advocacy message, persons responsible and timelines. Stakeholder analysis was carried out by each NGO and sensitisation workshops with police officials, district administration, panchayats/local politicians, health care service providers, pimps and madams, and regular partners were planned and carried out at regular intervals.

In addition, there was huge effort made in educating the community on their legal rights. Lawyers were engaged in each district and NGOs held legal literacy camps in their DICs at
regular intervals. These camps also doubled up as STI screening camps. The lawyers also supported individual cases of exploitation and provided legal aid as per need.

**Alliance India Advocacy Actions at Multiple Levels**

- **TI level**
  - Core advocacy groups (CAG)
  - Crisis response teams
  - Capacity building of CAG, CBO, and NGO

- **District level**
  - Police meets for discussing areas of conflict, understanding of programme, and role of community and garner support.
  - Advocacy for social inclusion: Communities were provided legitimised space in various platforms through constant efforts with Line departments of the district and state government towards increased access for entitlements and welfare schemes
    - District convergence meetings
    - Know Your Doctor and entitlements campaign

- **State level**
  - Police advocacy
  - Government Order to district police officials for supporting prevention efforts of NGOs and to stop harassment of outreach staff for carrying condoms.
  - Coordinate the signing of outreach ID cards by Superintendent Police (SP) of the district.
  - Coordinate the sensitising and HIV/AIDS awareness workshops for police personnel at training centres and police stations.

- **Media and legal advocacy**
  - Media consultations – Role of community in prevention, impact of negative and positive reporting
  - District level media consultations – Capacity building cum media interaction

**Advocacy Activities at the TI level**

- **Core Advocacy Group (CAG):** Community centric advocacy systems were instituted through the formation of CAG, mainly to address the violence and discrimination faced by community members in their daily lives. The composition of the group consisted of one FSW and one MSM at site, NGO and district level. In addition, project director (PD) of the NGO and a lawyer were also the group members at all levels. The PD was the moderator of CAG and the group was supported by the program officer and program manager, Advocacy of Alliance India for the district. The CAG met once a month to review the incidents of violence and advocacy issues of each site and to find best possible solutions. Based on the data of violence issues, advocacy meetings with
different stakeholders were planned. The CAG members helped build relationships and garner support from various stakeholders actively.

- **Crisis Response System:** In order to address violence especially within the sex work circuits for both FSW and MSM/TG populations and to facilitate the HIV prevention work by ORW and PEs, the project established community led violence addressing mechanisms through CBOs and partner NGOs. Specific community teams have been built for the purpose of monitoring and attending to instances of crisis for ensuring vulnerability reduction at the hot-spot level. These 24-hour response community teams comprised of 5-7 members at each hotspot, ensuring the presence of at least 2-3 members at any given time. Clear communication lines were established though mobile phones and verbal signs to respond to incidents of violence or extortion. The teams focused on relationship building and conflict resolution than confrontation with the beat constables, goons and clients, leading to reduction in violence against the sex workers. The groups called themselves CAT – community actions teams, EAT – emergency action teams, and RAT – rapid action teams. The core advocacy group and the crisis response teams met at least twice a month to document issues addressed, share the information about the perpetrators (individuals, names, description) and to develop strategies to counter violence, extortion and coercion.

**Advocacy Activities at the District Level**

- **Police Sensitisation:** Over 20,000 police officials were sensitised on HIV in 2006 and as a result, reduction of violence by police personnel on the community members was observed. The Police has since been supportive to the program in many districts. Some NGOs conducted monthly planning meetings at the local the police stations and

**Structure of CAG**

<table>
<thead>
<tr>
<th>Core Advocacy Group Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>One representative of each community group at all levels. (Eg: FSW/TGs/MSMs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District CAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO CAG</td>
</tr>
<tr>
<td>Sites CAG</td>
</tr>
<tr>
<td>24-hour response team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs/IPs</td>
</tr>
<tr>
<td>Sites</td>
</tr>
<tr>
<td>Hot spots</td>
</tr>
</tbody>
</table>

4-8 numbers for each hot spot
the KPs facilitated the HIV/AIDS awareness sessions at police training camps. Police advocacy was continued every year until 2012.

- **Social Entitlements and Schemes**: Starting 2006, the outreach teams were involved in increasing access to social welfare schemes and entitlements. In the initial years, focus was on entitlements, restricted to at least one entitlement (voter ID cards, ration cards, bank account, etc.). By 2008, the milestone had shifted to each KP having at least two entitlements and by end of 2008, 60% community members had at least two entitlements with more than 90% having at least one entitlement.

- **District Convergence Meets and Solidarity Events** were organised at Chittoor, Nalgonda, Khammam, Ananthapur, Warangal and Medak by involving all district collectors and the line departments. These events helped increase access to social welfare schemes. The meetings were organised by district CBO networks with support from NGO/CBOs. During these meets, community members interfaced with all the district officials and explained the need for increased access to welfare schemes. Due to convergence meets, line departments were instructed by the district collector to consider sex workers as special category and approve the schemes under special provision.

- **Know Your Doctor and Entitlements Campaign** also focuses on building linkages with all the line departments. “Know your doctor” campaign was a district level event where the KPs could interact with key health officials to express their grievance and seek answer to questions related to health and entitlements. Core committee with community leaders was formed in each district who played vital role in advocating with key departments (SC/ST/BC corporations, housing, civil suppliers, WCD, legal service authorities).

- **Community Representation at DAPCU Steering Committee**: To strengthen integrated advocacy efforts at district level, a strong need for representation of community in the steering committee of DAPCU was felt. A formal request was made to the district collectors and APSACS and the District Collector of other districts. Currently, community representatives are on board of DAPCU in four districts: Chittoor, Khammam, Karimnagar and Warangal.

**Advocacy Activities at the State Level**

- **Futures Group - Police Advocacy**: On Mar 25, 2006, the Futures Group, an Avahan technical support partner for strategic advocacy, organised a meeting with the state

---

**Capacity Building of CAG and Crisis Response Teams**

The crisis team members, CAG, CBG facilitators and leaders, and District network members were trained on crisis response systems, evidence based advocacy and development of advocacy plans, and legal literacy. The team members were provided training on following issues:

- **Basic Advocacy Skills workshop**: Basic roles and responsibilities, advocacy definition, role of community in advocacy, sharing of issues, identifying issues, prioritising issues, communication skills, stakeholder analysis, developing NGO Advocacy Plan with activities for handholding support to CAG.

- **Advanced Advocacy Skills workshop**: Presentations on best practices, achievements, visioning, case studies, role plays, legal issues and leadership, negotiation, and communication skills, developing CBO advocacy plan with support of CAG and crisis response teams.

- **Media advocacy skills workshop and media consultations and capacity building.**

- **Legal Literacy and legal awareness**: Appointment of lawyers at each site and awareness building on legal issues around trafficking, and developing strategy to reduce pressure by anti-trafficking authorities.
police officials, Alliance India and HLFPPT to take forward the advocacy strategy with the police at the state level and sensitisise them on certain field level realities. Shri K. Jana Reddy, Honourable Home Minister of AP graced the event and at the conclusion of the sessions, passed oral directives on concerns raised by the sex-workers. A large number of police personnel – district police officials from the rank of DSPs, inspectors, senior police officials from the State Police Academy, and other senior officials took part in the meeting.

- **Alliance India/APSACS Police Advocacy:** In 2011, Alliance India took lead in Police Advocacy roll out. Police Advocacy module was developed by Alliance India in collaboration with APSACS and state level police advocacy was organised in which DGP Andhra Pradesh participated. This event was followed by district level workshops.

- **Legal Services and Support:** Legal literacy for the community was introduced in 2006. Lawyers were engaged by all TIs who trained the CBO and CAG members on legal rights and services. Legal literacy manual was developed for the purpose. The NGOs organised legal literacy events in their DIC on regular intervals. The lawyers also advised the CAG on how to respond to the incidents of violence and legal advice was also given to community members whose rights were violated or who were victims of violence. Later, TIs established linkages with District Legal Service Authority (DLSA). A total of 118 community members (FSW and MSM) have been accredited to work as paralegal volunteers in five districts.

- **Media Advocacy:** 56 CAG members, 22 CBO members and 28 NGO staff were trained in media communication in 2007. A successful outcome of this training was a visit of representatives of national level media (The Times of India, The Hindustan Times, Press Trust of India, and United News Information Bureau) to CERA, an implementing NGO based in Ananthpoor District, to build greater understanding of the role of the community and the effectiveness of peer education system in the implementation of the Avahan program. Media advocacy activities included providing strategic and operational support through training, mentoring and the dissemination of literature and information. A legal literacy manual was published by Alliance India to support this initiative. This manual addresses the legal issues faced by the KPs and provides information on their rights. At the district and site level, local reporters were sensitised and were invited/felicitated on various occasions as a strategy to recognise their contributions of positive stories about the community in the local media. The local vernacular print and the electronic media featured positive stories, depicting the issues and challenges faced by the key population and their contributions in a large scale prevention programme.
Advocacy Through Coalition

- Community members participated in the Pension Parishad Rally at Delhi and presented the demands of the community members to consider the FSW community as a special group for providing pension of Rs. 2000/- per month for the old age sex workers. In this effort, CBOs organised signature campaign and voiced out their concerns to parliamentarians during the budget session. Community leaders from six Avahan states participated and presented testimonials by actively participating in a two-day seminar organised by CFAR. The consolidation report highlighted the need for inclusion of sex workers under universal pension scheme and was presented to the planning commission. However, the planning commission chairperson assured community leaders review of the proposal during their mid-term review meeting.

- Organised signature campaign for the Delhi Rape incident and shown the solidarity by participating in the Midnight March with the signature banners at state level from all the CB.
The purpose of monitoring was to review progress on an ongoing basis, identify problems, provide timely solutions, and modify the work plan accordingly. A robust monitoring system was built right from the inception of Avahan programme for regular tracking of the progress and for assessing if the desired processes were followed and if the expected outputs of the programs were achieved. Also, participatory approaches to monitoring were adopted by Alliance India and implementing NGOs.

In Alliance India led interventions, the robust monitoring information system (MIS) developed by Avahan for data collection and reporting was complemented with KP-led monitoring systems that provided feedback. These community monitoring systems included quality assessment of clinical services (CSRC), participatory site assessments, and feedback from KPs (suggestion box in DIC, exit interviews in the clinics). In addition, bi-annual biological and behavioural surveys were planned by Avahan to assess programme impact. Research activities were part of the annual action plan to improve and strengthen the programme.
Evolution of CMIS

Data Collection Tools: Data collection plays key role in a project cycle and it has different layers. Each level requires various tools to collect, collate and analyse data. During initial stage of Avahan, 2004-2005, Alliance India designed its own data collection formats/tools to fulfill the needs of monitoring and analysis. Paper based formats were used for capturing outreach and clinic data by outreach and clinical teams respectively. The formats included:

- **PE/ORW Daily Diary:** Capturing information on the number of KPs met and provided with HIV prevention information, whether referred to Mythri clinics for STI/HIV services, number of condoms given, etc. It also records the risk analysis of each KP.

- **Clinic Attendance Form:** Whenever a KP attended the clinic, ANM and the doctor used clinic attendance form to record sexual behaviour, findings of clinical examination, diagnosis, treatment given, follow up dates and referral, if any. An individual file was maintained for each KP with details of each visit in a separate clinic attendance form.

- **Counselling Register:** In the STI clinic and the DIC, the counsellor provided risk-reduction counselling as well as STI/HIV care information. The details of type of counselling provided, and follow ups along with risk assessment was recorded during each visit by the counsellor.

- **Clinic Register:** The information from clinic attendance form was entered in clinic register, a format that was used to collate information of each clinic in terms of KPs visited and the service provided (treatment for STI, counseling, referral, TB screening, condoms, partner treatment, etc.).

- **DIC Register:** Number of KPs attending the DIC were recorded along with reason for attendance.

- **Condom Register:** Details of condoms procurement and supply were entered in this register.

- **Referral Register and Referral Slips:** For tracking all the referrals provided for STI/HIV/TB care and support services.

- **Crisis Response Format:** Was used by ORWs to record any incident of violence or discrimination faced by the KPs and whether or not it was responded to within 24 hours by the CAG teams.

- **Event Register:** To document the events organised in DIC or hotspots.

- **Monthly Tracking Tools:** Tracking tools were developed to help the ORW in developing their monthly plans, ensuring that they are able to meet their target population. The ORW was given their targets for the month and ticked it off once they met the KP.

- **Data Reporting Tools:** In the first two years, NGOs reporting formats were paper based in excel format and included separate tables on outreach, clinic visits, STIs diagnosed and treated, and other activities. The reports were sent to Alliance India staff every month who compiled monthly reports for the donor. In 2006, once CMIS started, a monthly report format as given by Avahan (P2 format) was used by NGO to generate reports. The monthly report was forwarded to Alliance India M&E and programme teams by 2nd of every month. It was checked for quality and NGOs were given inputs on correction of errors, if any. The corrected reports were compiled and shared with
In addition to monthly quantitative reports, NGOs also provided:

- **Quarterly Narrative Reports**: Each NGO submitted on a quarterly basis, a narrative report on the progress made in achieving the outputs. Further, they also sent a quarterly expenditure statement against the budgets. The reports were to be sent to Alliance India by every 4th of January, April, July and October to their respective project officer/senior project officer in charge.

- **Annual Reporting from NGOs**: Each NGO prepared annual report prior to the ‘review and re-plan’ towards end of the year. These reports were shared with the respective POs in charge for annual performance assessment. The annual report was based on work planned and budget spent in each cluster/component. An analysis was done to check for accomplishment of activities against annual work planned and assess the outcomes.

### Table: Showing the tools used and persons responsible

<table>
<thead>
<tr>
<th>S No.</th>
<th>Type of tools / registers being used</th>
<th>Key person/s responsible for filling up</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>KP Reach Form</td>
<td>Outreach worker</td>
<td>Project coordinator</td>
</tr>
<tr>
<td>2</td>
<td>KP tracking format+ PE / ORW</td>
<td>PE / ORW</td>
<td>Field Coordinator / Outreach worker</td>
</tr>
<tr>
<td>2</td>
<td>PE daily format</td>
<td>Peer Educator</td>
<td>Outreach worker</td>
</tr>
<tr>
<td>3</td>
<td>ORW daily format</td>
<td>Outreach worker/s</td>
<td>Project coordinator</td>
</tr>
<tr>
<td>4</td>
<td>Group session register</td>
<td>Outreach worker/s</td>
<td>Project coordinator</td>
</tr>
<tr>
<td>5</td>
<td>Events Register</td>
<td>Project coordinator and other staff of NGO</td>
<td>Project coordinator</td>
</tr>
<tr>
<td>6</td>
<td>Counselling register</td>
<td>Counsellor posted at the clinic for the program</td>
<td>Counselor and Project coordinator</td>
</tr>
<tr>
<td>7</td>
<td>Clinic based registers including referral cards</td>
<td>Doctors/Paramedics staff</td>
<td>Doctor For reporting the projecting coordinator will take the help of paramedic</td>
</tr>
<tr>
<td>8</td>
<td>Stock registers (Medicines, other drugs including STI kits).</td>
<td>Paramedic/Doctors</td>
<td>Paramedic staff/doctor. Reporting purposes project coordinator will take the help of paramedic staff</td>
</tr>
<tr>
<td>9</td>
<td>Non clinic stock registers – Condoms, IEC, BCC etc.</td>
<td>Accountant cum administrative/project coordinator</td>
<td>Project Coordinator</td>
</tr>
<tr>
<td>10</td>
<td>Drop Center Registers</td>
<td>Point person appointed by the Project coordinator (it is recommended that KP could be given responsibility by turns say for period for a week or so)</td>
<td>Project Coordinator</td>
</tr>
</tbody>
</table>
Following information flow system was put in place:

**NGO Level:** The MIS officer compiled the data received from field and entered it in CMIS/site base database as per reporting requirements on monthly basis. The monthly reports were generated and shared with PD/PC before sending it to respective Program Officer in charge at Alliance India by 2nd of every month. The MIS officer, with support from PC, would also do basic analysis on the data collected and shared the same with the PD/PC for assessing the project progress against plans and milestones on monthly basis. Data quality check systems were also put in place by randomly generating a list from the site-based database to check the persons met and also verifying the new contacts made by visiting hotspots at least twice a week. At the NGO level, the analysis was mainly conducted to compare the outputs achieved against activities performed. On monthly basis the MIS officer would generate trends for the last six months and share the same with the PD/PC/APC/PO from Alliance India. The information was used for review and re-planning.

**At Alliance India level:** Project officers/Senior Project Officers ensured receipt of the monthly database and reports from their respective NGOs by 2nd of every month and performed basic checks:

- Number of new KPs identified in a mandal (Seeing the past trends of identifying new KPs to know if the number are realistic).
- Number of KPs availed services for the first time.
- Total number of KPs yet to avail at least one service (total KPs identified – total KPs availed first time services). If the gap more than 10% of the total identified, it was verified with the NGO.
- Number of KPs dropped out of project in a given month (justification was obtained from the NGO where the drop outs were consistently reported every month).
- Number of individual KPs met on one-on-one basis by the PE and ORW.

Monthly analysis of trends of NGOs, districts and regions was conducted by respective teams and used for identifying the gaps and for planning corrective action. The analysis was being shared at the following events: quarterly review meetings by SPOs; BMGF review meetings; R&R review (NGO wise by the respective PO in-charge and the technical staff in charge of respective technical components).

**From Excel database to CMIS database**

Excel Based Reporting Formats and Database: The outreach and clinical data collected in the field was collated and transferred to Excel based reporting tools for further analysis and reporting. Each project had thus generated database in Excel form by end of 2005. However, the Excel formats were generally not suitable for handling large quantity data or individual service delivery tracking.

Alliance India CMIS: In 2007, the new front end tool was developed and expanded to all TIs working with Alliance India. It was named as “AIAP CMIS”. Alliance India further developed the CMIS from Version 1 to Version 24, adding many more features along with online, SMS based tools. AIAP CMIS underwent many changes over the years, mostly to incorporate new indicators. Now APSACS is using the same AIAP CMIS features to track their ART- ICTC linkages for the people who tested positive in their ICTC centers in all 23 districts of Andhra Pradesh.

Strategic Information Management System (SIMS): By 2011, NACO had developed a national MIS for collecting HIV data from different stakeholders, including Targeted Interventions. The MIS officers of Alliance India TIs were trained on the system and entered the data in SIMS by 10th of every month, while reporting directly to SACS as well.
Good Practices in M&E

- **Online sharing of data** between NGOs and Alliance India, enabling Alliance India staff to check the data quality online. Remote technical support was provided through Team-viewer - a computer software package for remote control, desktop sharing, and file transfer between computers. The software also allows file transfers between computers, group chat and web chat, making it easy for the Alliance India technical officer to provide technical support.

- **QlikView software** was used in addition to the CMIS in 2010. With an easy end-user interface, QlikView’s simplicity lets anyone easily consolidate, search, visualise, and analyse all their data for unprecedented insight. It provides answers in an instant, on screen, without having to wait around for any report. With just one click, visually rich, interactive dashboards to NGO level detail can be accessed and the data can be seen in the form of charts, tables, graphs — every kind imaginable. Unlike other tools that create confusion, errors, and administrative overhead, Qlik View’s visual design elements provide the flexibility to bring multiple viewpoints into one, simplifying the end user experience and accelerating monitoring and reporting process.

- **SMS data transfer, update and sharing**: Presence of mobile phones everywhere makes use of this technology for data collection very attractive. SMS were used for data collection from the field (condom data from NGOs, HIV data from the ANM and ART center data from community liaison officer).

Community Led Monitoring

Alliance India built in many community-centered mechanisms for monitoring the NGO performances to ensure the services were KP-friendly and of good quality. These mechanisms included:

- Participation of community representatives in annual and half-yearly reviews and planning at the project level
- Clinic Administrator was responsible for monitoring the quality of services on a day to day basis and also conducting exit interviews of clinic attendees. Any issues of breach in confidentiality, discriminatory approach of the medical personnel, or poor quality of services were reported to the NGO as well as CSRC.
- Clinic Service review committee addressed issues of quality of clinical services

New Initiatives: New activities got added continuously over the years and this led to change in core indicators over the years. Following is the list of indicators introduced after inception of CMIS in 2007:

- ICTC Compiler
- SIMS Online- Validator and Error Check Tool
- Geographical Data Compiler
- One click linkage between existing CMIS and NACO SIMS
- Online community mobilisation data collection, reporting and analysis website
- Core indicators (monitored through P2 Report every month)
As mentioned earlier, new activities got added continuously over the years and this led to change in core indicators over the years. Following is the list of indicators introduced after inception of CMIS in 2007:

### Key Indicators of CMIS

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outreach</strong></td>
<td>Size estimation of target groups</td>
<td>Enter once and then update as and when needed</td>
</tr>
<tr>
<td></td>
<td>Number of intervention districts covered</td>
<td>Enter once and then update as and when needed</td>
</tr>
<tr>
<td></td>
<td>Number of project offices, DICs or supported clinics</td>
<td>Enter once and then update as and when needed</td>
</tr>
<tr>
<td></td>
<td>Number of intervention related project staff</td>
<td>Enter once and then update as and when needed</td>
</tr>
<tr>
<td></td>
<td>Number of active, unpaid peer educators</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of peer educators that discontinue working</td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>Program Coverage</strong></td>
<td>Total number of individuals registered in the project</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of individuals from the target group that have discontinued with the project services</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Capacity Building</strong></td>
<td>Number of peer educators trained</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of training sessions for peer educators</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of project staff trained</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of training sessions for project staff</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of health care providers trained</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of training sessions for health care providers</td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>HIV/STI Prevention Communication</strong></td>
<td>Number of 1-1 contacts</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of individuals reached by 1-1 HIV/STI prevention communication</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of contacts reached by 1-group HIV/STI prevention communication</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of interpersonal HIV/STI prevention communication sessions (1-1 &amp; 1-group)</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of condoms distributed – free</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of referrals to STI services</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>STI Service Indicators</strong></td>
<td>Total number of individuals receiving STI consultations</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of STI consultations</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number and distribution of STI syndromes</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of STI treatments distributed by type</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of individuals receiving presumptive treatment (first time only)</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total instances of presumptive treatment given</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Number of clinics reporting any STI drug stock outs within last month</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Total number of individuals counseled</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Empowering Key Populations for Sustainable HIV Prevention

| Total number of individuals tested for syphilis | Monthly |
| Total number of individuals found reactive for syphilis | Monthly |
| Total number of individuals found reactive for syphilis provided treatment | Monthly |

**B. Provider Referral Clinics**

| Number of individuals receiving STI consultations in a provider referral clinic | Monthly |
| Number of STI consultations by a provider referral clinic | Monthly |
| Number and distribution of STI syndromes by a provider referral clinic | Monthly |
| Number of STI treatments distributed by type in a provider referral clinic | Monthly |

**Community Mobilisation and Enabling Environment**

| Number of individuals currently enrolled in a collective or a self help group | Monthly |
| Number of self help groups | Monthly |
| Number of collectives or self help group meetings | Monthly |
| Number of organisations that the NGO used for referrals not related to STI | Quarterly |
| Number of individuals referred for services not including STI services | Quarterly |
| Number of target group members attending local, national, or international meetings/conferences | Quarterly |
| Number of target group members presenting in local, national, or international meetings/conferences | Quarterly |
| Number of community meetings or events | Monthly |
| Number of meetings with local administrative authorities to familiarise them with on ground activities | Monthly |

**Additional Indicators from 2008:**

- Incidents of crisis incidents reported
- Number of crisis incidents reported addressed within 48 hours
- Number of FSW/MSM/IUD linked with social protection schemes
- Number of FSW/MSM/IDU referred for ICTC
- Number of FSW/MSM/IUD verbally screened for TB
- Number of FSW/MSM/IUD referred to DMC for sputum check
- Number of FSW/MSM/IUD diagnosed with TB
- Number of FSW/MSM/IUD with TB linked with DOTS
- Number of FSW/MSM/IDU tested for HIV
- Number of FSW/MSM/IDU detected positive for HIV
- Number of FSW/MSM/IDU linked to ART center.

The ICTC and HIV indicators were monitored by Alliance India since 2008 but Avahan initiated their tracking only later in second phase as this was an important indicator for NACO led programmes.

**Milestones**

Yearly milestones were set for each TI depending upon age of the TI, e.g., a three year old TI was expected to have more than 80% monthly outreach and quarterly RMC with 60% of target population tested for syphilis twice in a year. Performance of TIs was measured against these set milestones.
Evaluation of Projects
Apart from regular monitoring, the projects were evaluated for their performance regularly. In addition, impact evaluations studies were carried out by Ahavan to check if the interventions were achieving the desired results.

- **Annual and Half-yearly Reviews**: Each NGO performance was reviewed based on the milestones and workplans for the coming year developed based on the needs identified. After six months, there was another review and mid-year corrections were made in workplan and budgets, if required.

- **External Evaluations**: These started at the end of the first phase and thereafter, every year as suggested in NACP III guidelines. NACO evaluation tools were used for the purpose and NGOs were evaluated both on programmatic and financial aspects.

- **Impact Studies**:
  - **Integrated Biological and Behavioral Assessment (IBBA)**: Two rounds of IBBA were commissioned in a sample population by BMGF, first in 2006 and second in 2009. The districts selected included Karimnagar, Warangal, Hyderabad and Chittoor. The second round clearly demonstrated increased use of consistent condom with regular partners, and decrease in STI and HIV prevalence in the study population.
  - **Behaviour Tracking Surveys (BTS)**: Carried out in five intervention districts in 2009, 2010 and 2011 on sample population of FSW and MSM, the surveys measured the impact of interventions on sexual behaviour and HIV vulnerability. The IBBA findings were corroborated with BTS which showed the positive impact on communities (increased condom use even with regular partners; decreased violence, especially from the police; increased community collectivisation).

Capacity Building for M&E
The capacity of implementing partners was built through:

- Training of PEs, ORWs, ANMs, and clinic administrator on data collection formats as part of thematic trainings.

- Hands-on training of the MIS officers: three-day workshops were organised twice in a year for new participants and two-day refresher trainings undertaken every year.

- On-site technical support through monitoring visits of the technical officers of M&E team, technical officers of clinical services, and programme officer helped strengthen the skills.

- Technical support also provided on-line by the technical officers of M&E team.

- Old experienced and skilled MIS officers were used as resource persons to provide on-site support to those who needed it, such as new recruits.

- From 2010 onwards, monthly MIS days were organised in the first week of every month. MIS officers would gather their data which was checked by M&E team and gaps were addressed at the same time.
Phase I of Avahan (2004-2009) established infrastructure and saturated coverage of key populations for HIV prevention services provision that translated into clearly declining trends of HIV infection in general population and sex workers (as indicated by HSS). Phase II (2009-2014) focused on sustaining the impact achieved in Phase I through transfer of the projects to their natural owners (the communities and the government) and strengthening coordination with government, building capacities of the communities, disseminating best practices, and consolidating the prevention efforts initiated in phase I. New strategies for making prevention services sustainable were tested and community capacity building efforts were focused with renewed vigour to enable CBOs to manage TI that were being prepared for smooth transfer to the government. This section will focus on the process followed for transitioning the TIs to government funding and management.
Timelines of transition to the government:
- Transfer of 10% of communities in year I (August 2009)
- Transfer of 20% of communities in year III (March 2011)
- Transfer remaining 70% of communities in year IV (March 2012)

**District Redistribution:** Hand over process to the SACS involved nine districts even though Alliance India had been working in 14 districts of Rayalseema and Telengana. In 2010, NACO decided that one organisation should work in one district for ease of administration. So if more than one organisation was working on HIV prevention in one district, the TIs were transferred to the organisation with larger presence. As a result, TIs from Rangareddy, Nizamabad, Adilabad, Mehboobnagar, and Kadapa with approximately 7,000 KPs were handed over to APSACS while two TIs from Chittoor and one from Warangal were given to Alliance India for management. By end of 2010, Alliance India was working in only seven districts, having already handed over Kurnool and Hyderabad. Alliance India had to keep providing monitoring support to all the transferred TIs until the time of their transition and in addition, also had to provide technical support to migrant TIs (managed by APSACS) in Warangal and Chittoor districts.

The TIs transferred in each phase are given in the tables below:

a. Handover to APSACS in 2010 as part of District Distribution:

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of the NGO Partner</th>
<th>District</th>
<th>No. of KPs</th>
<th>FSW</th>
<th>MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LEPRA - Nirmal Project</td>
<td>Adilabad</td>
<td>671</td>
<td>492</td>
<td>179</td>
</tr>
<tr>
<td>2</td>
<td>LEPRA - Kamareddy Project</td>
<td>Nizamabad</td>
<td>911</td>
<td>911</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>LEPRA - Hayathanagar Project</td>
<td>Rangareddy</td>
<td>1,673</td>
<td>1,327</td>
<td>346</td>
</tr>
<tr>
<td>4</td>
<td>AIRTDS - Adilabad Project</td>
<td>Adilabad</td>
<td>1,513</td>
<td>1,090</td>
<td>423</td>
</tr>
<tr>
<td>5</td>
<td>SAMPURNA - Thandur Project</td>
<td>Rangareddy</td>
<td>555</td>
<td>476</td>
<td>79</td>
</tr>
<tr>
<td>6</td>
<td>PAID - Kadapa Project</td>
<td>Kadapa</td>
<td>562</td>
<td>0</td>
<td>562</td>
</tr>
<tr>
<td>7</td>
<td>SASD</td>
<td>Mahabubnagar</td>
<td>641</td>
<td>279</td>
<td>362</td>
</tr>
<tr>
<td>8</td>
<td>SNEHA</td>
<td>Nizamabad</td>
<td>2,003</td>
<td>1084</td>
<td>919</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>8,529</strong></td>
<td><strong>5,659</strong></td>
<td><strong>2,870</strong></td>
</tr>
</tbody>
</table>

b. Hand Over to APSACS as part of Planned Transition Process:

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>District</th>
<th>NGO/CBO</th>
<th>No. of TIs</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10% Transition (July 2009)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Kurnool</td>
<td>MERIBA, AARDIP, GAMANA, CERD</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hyderabad</td>
<td>LEPRA India</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>****</td>
<td></td>
<td></td>
<td><strong>6,800</strong></td>
<td></td>
</tr>
<tr>
<td><strong>20% Transition (April 2011)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>MEDAK</td>
<td>SCOPE, LEPRA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Warangal</td>
<td>RDMM, MARI, SYO, Pragathi</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>****</td>
<td></td>
<td></td>
<td><strong>11,590</strong></td>
<td></td>
</tr>
</tbody>
</table>
70% Transition (April 2012)

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Organizations</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Chittoor</td>
<td>PASS (2), PMMS, CORE, RSS, Janchetna,</td>
<td>9</td>
</tr>
<tr>
<td>2.</td>
<td>Anantapur</td>
<td>HANDS, Chaitanya (2), MEOS, KREDS, RIDS, Jan-Jagruthi, CERA (2), FORD</td>
<td>10</td>
</tr>
<tr>
<td>3.</td>
<td>Karimnagar</td>
<td>Reach, GNNS, VMPS</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Khammam</td>
<td>Jagruthi, SIRI, Secure</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Nalgonda</td>
<td>LIFE, GCS</td>
<td>2</td>
</tr>
</tbody>
</table>

31,984

July 2012

<table>
<thead>
<tr>
<th>District</th>
<th>Organizations</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anantapur</td>
<td>SMMS, PMMS</td>
<td>2</td>
</tr>
<tr>
<td>Khammam</td>
<td>Jagruthi-Yellandu, SECURE,Badrachalam</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5,154</td>
</tr>
</tbody>
</table>

April 2013

<table>
<thead>
<tr>
<th>District</th>
<th>Organizations</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nalgonda</td>
<td>SCEED, MPHS</td>
<td>2</td>
</tr>
<tr>
<td>Medak</td>
<td>Seva Sangam</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3,238</td>
</tr>
</tbody>
</table>

Orientation on Transition: In the first 10% transition, Alliance India team visited NGOs and informed them about transition, its importance and plans. It was observed that most NGOs at this time were nervous as they were not anticipating this would happen, even though they had been informed at the time of proposal development in November 2008. Based on the lessons learnt from the first phase of transfer, all the NGO Chief Functionaries and key staff members of the remaining TIs, along with CBO functionaries, were introduced to the concept of transition one year prior to the proposed date of transition. Orientation on the importance of transition, role of NGO during the transition phase, the processes and steps for transition were discussed in detail and their doubts and fears allayed. The experiences from the previous batches of transition were considered and disseminated to the final batch of TIs to be transitioned. Project Director, APSACS, JD-TI, Avahan representatives and TSU representatives facilitated in addressing apprehensions of TIs about the transition. The representatives of TIs already transitioned also participated in orientation meetings and talked about their experiences of the transition process. This helped allay the fears of community and NGOs about working with government.

Phases of Transition

- **Ten Percent Transition:** In first phase, 10% of KPs (6,800) from Kurnool and Hyderabad districts was transitioned to APSACS in July 2009. These included five TIs (Meriba, AARDIP, Gamana and CERD from Kurnool and HYLEP/Lepra from Hyderabad). These TIs were selected on the basis of low prevalence of HIV and STI in the district and performance of these TIs being ranked “consistently good” or “good” as seen by community diagnostic tool, capacity assessment tool, and internal assessments.

- **Twenty Percent Transition:** In April 2011, next batch of 20% population was handed over to SACS (six interventions of Warangal and Medak). The transitioned NGOs were SCOPE in Zaheerabad, LEAPRA in Ramayampet and Sangareddy, Rudrama Devi MahilaMandali (RDMM) in Warangal, MARI-1 in Warangal, MARI-2 in Bupalpalli,
Sarvodaya Youth Organisation in Thorrur. Total population of these TIs included 4,722 KPs (2,726 FSW and 1,995 MSM) in Warangal and 1940 (only 44 MSM) in Medak. The transition plan included one more TI from Sangareddy, Medak. Alliance India appointed “Transition Manager” to coordinate with Avahan, NACO, APSACS, TSU, NGOs, CBOs, and other stakeholders. The Transition Manager responsibilities include following NACO guidelines on transition and effect a smooth transition. As part of post transition support, it was also agreed that Alliance India would continue capacity building and monitoring support to the Alliance India transitioned interventions to facilitate smooth integration of these interventions in the APSACS program. As a part of the preparation for eventual transition, an internal evaluation team was constituted comprising of Programme and Finance specialists for evaluating the NGOs to mitigate issues before hand. In addition, joint reviews of project by Alliance India and TSU Officers were conducted every month of all TIs in the transitioned districts along with the DPM, DAPCU of the district and Transition Manager.

- **Seventy Percent Transition**: In line with 70% transition plan, APSACS and Alliance India had consensus to transition 34 TIs in six districts of Andhra Pradesh. Accordingly transition baseline assessments for all TIs were completed in November, December 2011. Based on this report and another review by APSACS in early 2012, 27 TIs were taken over by APSACS in April, 2012. At the time for last 70% TI transfer, NACO/APSACS decided not to take over the TIs with poor performance. Seven TIs had been transitioned to CBOs by Alliance India and four of these still required further hand holding. Also in 2011, management of TIs changed due to termination of previous TIs and the new management also needed more capacity building. So hand over of four TIs to APSACS was delayed for three months after the scheduled transition and by one year for another three TIs. A detailed post transition support plan was prepared for the year April 2012 to March 2013. The TI wise post transition plans were developed based on the NACO assessment findings, field observations and data. Alliance India provided handholding support to the TIs for each of the district in the areas of programme management, support to clinical services, capacity building, M&E, mainstreaming, community mobilisation, review, etc.

- **Delayed Transition for Seven TI**: At the time for last 70% TI transfer, NACO/APSACS decided not to take over the TIs with poor performance. Seven TIs had been transitioned to CBOs by Alliance India and four of these still required further hand holding. Also in 2011, management of TIs changed due to termination of previous TIs and the new management also needed more capacity building. So hand over of four TIs to APSACS was delayed for three months after the scheduled transition and by one year for another three TIs:

### Table: Transition of Final 70% TIs

<table>
<thead>
<tr>
<th>Districts (TIs)</th>
<th>No. of TIs transitioned</th>
<th>Population Transformed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>April 2012</td>
</tr>
<tr>
<td>Chittoor (9), Ananthapur(10), Karminagar(3), Khammam(3), Nalgonda(2)</td>
<td>27</td>
<td>31,984</td>
</tr>
<tr>
<td>Ananthapur(SMMS, PMMS) Khammam (Jagruthi-Yellandu, SECURE-Bcm)</td>
<td>4</td>
<td>5,154</td>
</tr>
<tr>
<td>Nalgonda (SCEED, MPHS) &amp; Medak (Seva Sangam)</td>
<td>3</td>
<td>3,238</td>
</tr>
</tbody>
</table>
A detailed post transition support plan was prepared for the year April 2012 to March 2013. The TI wise post transition plans were developed based on the NACO assessment findings, field observations and data. Alliance India provided handholding support to the TIs for each of the district in the areas of programme management, support to clinical services, capacity building, monitoring and evaluation, mainstreaming, community mobilisation, review, etc. The post transition support included the following:

- All the programme officers were based at district headquarters.
- All the TIs were visited by PO’s at least ten times in year, the visits were prioritised based on the required and support needed. In total, 360 support visits to the TI were made during this period (April 2012-March 2013) were carried out, apart from the visits to the districts on the occasion of facilitating the district reviews and other central activities. During the field visits support was extended to the TIs in the areas of BCC, management, capacity building, establishing linkages, etc.
- Joint field visit plans were developed by Alliance India and TSU POs and in total 72 joint field visits are completed during this period.
- Alliance India PO’s participated in the six video conference organised by APSACS during this period.
- Support extended to IDU and Migrant interventions in Chittoor district, PO involved these TIs in the district reviews and also made six visits, apart from two visits by TO.
- Six months STI and ICST stocks were provided to the TIs to ensure uninterrupted supply
- Technical Officer (Clinical Services) made 62 technical support visits during the period. During the visits ensured that the clinical systems and protocols are maintained as per the prescribed standards.
- All the medical officers and ANMs were provided on field capacity building on SCM protocols
- New medicals officers were provided institutional training in the areas of clinical systems, SCM protocols, STI management and HRG sensitisation.
- ‘Know your Doctor’ campaign was conducted in the districts of Ananathapur and Karminagar to garner the support of the district administration in terms of referrals to the government health services, APSACS/TSU and DAPCU were active participants in these events.
- As part of mainstreaming process all the medical officers in the government sector along with the staff nurses and lab technicians and counsellors were trained on 23 NACO modules.
- NACO CMIS was collected, verified, validated by Alliance India on monthly basis; CMIS reports were consolidated and shared with APSACS.
- 13-indicator tool reports were collected from TIs and consolidation was done at Alliance India, the final consolidated report sent to APSACS and TSU.
- SIMS was introduced during this period.
- NACO PO quarterly assessment tool for April-June 2012 and July-Sept 2012 was done by Alliance India POs and shared with TSU.
- Monitoring and evaluation support in terms of validation and reporting. Also on adoption of revised UID number.
• Condom data captured on weekly basis and reported to APSACS.
• Technical officer (M&E) made 25 technical support visits during the period. During the visits provided on field capacity building to MIS Officers, verified data and analysed field data.

**Process of Transition**

Summary of the steps followed in the transition process are given below:

• **A Transition Team** was constituted at the Alliance India level and at the state level. To spearhead the transition activities at the Alliance India level, a new position of Transition Manager was created in 2010, prior to which senior program manager was responsible for coordinating all transition related activities.

• At the state level, **Transition Steering Committee** was constituted with members of all other stakeholders (SACS, TSU, BMGF, HLFPPPT). The transition team developed roadmap for the entire transition process in coordination with all other stakeholders (SACS, TSU, BMGF, NGOs, and the community). Series of meetings were held in early 2009 to clarify doubts and misconcepts of these stakeholders and to allay the fears of the community and NGOs. Roadmap was also developed for transitioning the TIs from NGOs to CBOs.

• **Selection of NGOs for Transition**: Following criteria was used for selecting the TIs/district for transition: ANC HIV prevalence; STI prevalence; district performance; one to one meeting; quarterly clinic visits; community groups status; crisis response teams; and whether NGOs have completed three years of partnership with Alliance India.

• **Transition Preparedness Tools**: Pre-transition assessment tools for programmatic and financial review of NGOs were developed by Avahan and used by the transition team for internal review of NGO performance. Baseline tools were filled in by the NGOs/CBOs to be transitioned and then validated by the respective programme officer from Alliance India.

• **Alignment with NACO’s Operational Guidelines for TI**: Orientation of Alliance India staff on NACP III guidelines for TI management was done in the end of April 2009. NACP guidelines, drawn from Avahan experience, were mostly similar to TI management by Avahan but differed significantly in cost, human resources and in terms of coverage numbers in each TI. It was important to understand the differences and take steps to align with both programmatic and costing guidelines of NACO. Guidelines for alignment to NACP III were prepared and all implementing partners were oriented on NACP III guidelines as well as on steps to be taken for alignment. Alignment for first 10% transition was done after NACO evaluation in April 2009 and other TIs were realigned by April 2010.

• **Review of NGO Performance**: Internal review (through a cross-cutting team from different departments) and capacity building process for the NGOs selected for transition was initiated from 6-9 months before transition.

• **External Evaluation**: All these TIs had to go through a pre-transition external evaluation by NACO/APSACS and external consultant. The decision for transfer to APSACS was based on the findings of this assessment. The findings also guided the post-transition
plan that was developed jointly with APSACS to decide on the areas of technical support by Alliance India for six months after transition. In the last phase, the evaluation was completed six months before scheduled transition and a pre-transition support plan was developed, the progress of which was tracked and reviewed by TSU every month.

- **Handing Over Notes:** Handing over notes were developed for all the TIs and handed over to APSACS at the time of transition. The notes detailed the achievements, gaps and strategies for covering the gaps.

- **Development of Proposals by TIs:** A joint proposal development workshop was organised before contracting with APSACS. Alliance India team facilitated the development of proposals by the NGOs/CBOs and submitted to APSACS after reviewing them on behalf of the TIs.

- **Contracting of TIs by APSACS:** Transition process was completed with signing of contracts between the NGO/CBOs and APSACS.

- **Post-transition Support:** APSACS, Technical Support Unit – AP and SLPs developed a detailed TI-wise post transition support plan, based on the NACO assessment findings, field observations and data. Post transition support was provided for one year for all TIs except the ones transitioned in July 2012 and March 2013. Handholding support was provided to each of the TIs in the areas of programme management, support to clinical services, capacity building, monitoring and evaluation, mainstreaming, and community mobilisation.

**Indicators during Prevention Period**
Over the course of Avahan implementation, Alliance India developed not only resource material for the NGOs and the community members but also ensure evidence-based programming through systematic research. A host of studies were conducted on various issues ranging from understanding of the geographical spread, sexual behavior and practices, and needs of the key populations to impact evaluation of the interventions. The learnings were disseminated with all stakeholders at the state level, published in peer journals and presented at international and national conferences. Above all, findings helped to guide the changes in programmes.
The following are various studies, manuals, books, and IEC materials developed by Alliance India as part of Avahan programme.

**Studies**

- **Mapping Studies (2004; 2006):** The mapping exercise was undertaken with help of TNS Mode and IMRB agencies in 2004 and 2005 in to estimate the population size for FSW and MSM Rayalseema and Telengana regions. Based on the IMRB report submitted in 2006, the programme was expanded to all mandals reported to have minimum of 100 KPs.

- **Participatory Site Assessment (2004; 2007):** This was done in 2004 with support from International HIV/AIDS Alliance with the objective of confirming the estimated numbers and locations of KPs, their sexual behaviours and risks as well as to mobilise the community. PSA became a regular practice and was undertaken whenever a new intervention was started, (e.g., in 2007 after the scale up).

- **FPP Baseline Study (2004):** The Baseline survey was carried out in year 2003-2004 by Administrative Staff College of India (ASCI) in all 40 sites of Rayalseema and Telangana identified with high numbers of FSW through broad mapping. A total of 6,648 FSW and 6,661 MSM were interviewed through a questionnaire and their blood and urine samples were collected for testing for STI.

- **Geographical Site Assessment (GSA):** The Academy for Nursing Studies gathered baseline information to complement and add to the site level details collected by the PSA. The GSA was conducted in all 26 sites (52 sub sites) spread across 12 districts of AP. The assessment was conducted between April and October, 2003.

- **Qualitative FPP Baseline Study (2004):** Undertaken by Institute of Health Systems, Hyderabad, focus group discussions were held with sex workers, MSM, and PLHIV to understand their vulnerabilities, barriers for safe practices and practices regarding health seeking behaviours, especially around STI.

- **Impact of Population Mobility on HIV Epidemic in Key Towns in Karimnagar District, Andhra Pradesh (2005):** A descriptive study done in Karimnagar district with huge out-migration of skilled and unskilled labour to Gulf as well as seasonal migration into the district for agriculture. The study helped understand the mobility pattern of key populations as well to plan intervention accordingly.

- **Capacity Assessment Study (2005):** Capacities of the NGOs selected for implementing the interventions were assessed by using the capacity assessment tool (CAT) developed by International HIV/AIDS Alliance. The training programmes were developed as per the need.

- **Assessment of Quality of Life of PLHAs and Influence of Support Groups in Improving the Same in Warangal District of Andhra Pradesh (2006):** The study was done as part of FPP to understand the PLHIV needs. The report has been published.

- **Condom Promotion Study (2006):** Synovate Ltd conducted a study to understand acceptability, accessibility, availability, and perceived affordability and feedback on Mythri condoms. Study was carried in four districts and feedback was sought from 1002 respondents (both FSW and MSM). Based on the study results, plan for social marketing of condoms was initiated.
• **Study on Issues Influencing Scaling-up, Replication and Social Marketing of Special Mythri Condoms (2007):** Alliance India had promoted Mythri brand of condoms along with water based lubes for the MSM. Catalyst Management Systems (CMS) did marketing research to find barriers to use and how to promote their social marketing.

• **FPP Endline Evaluation (2007):** After two years of implementation, FPP evaluation was undertaken by SIGMA Research Associates. Summary of report findings is included in the chapter on FPP.

• **NGO Evaluation (2008):** At the end of Avahan Phase I, all 40 implementing NGO partners were evaluated on their performance (programme initiatives, service delivery, community mobilisation and CBO initiatives, financial management, advocacy initiatives, governance) by Abhivruddi Associates – Hyderabad.

• **CBO Assessments (2009):** A sample of existing CBOs (30 out of 137 registered CBOs) were assessed to identify their capacities and capacity building needs as well as to prepare a road map for the establishment of community leaning site.

• **Behaviour Tracking Surveys (2009; 2010; 2012):** As mandated by Avahan, sample population of FSW and MSM was surveyed after five years of programme implementation to measure major outcomes and impacts of interventions on risk and health seeking behavior, community mobilisation and social vulnerabilities and to plan further actions accordingly. Several papers have been written to publish the findings in peer reviewed journals.

• **Condom Gap Analysis Study (2009):** The study was commissioned to understand the gaps between distribution and requirement of condoms among different risk groups and to suggest better planning mechanisms for strengthening the condom promotion programming which endeavors to meet the demands for condoms through free distribution and social marketing.

• **Sexual Reproductive Health Needs of FSW, MSM and TGs (2006; 2009):** Two studies were conducted by Akshara consultancies on SRH needs assessment – first in 2006 and then in 2009 in four interventions among FSW only.

• **Violence Study (2009):** Amoghah Research, New Delhi conducted a qualitative research to identify and understand various forms of violence faced by the FSW and MSM in the project area.

• **Anal Sex Study (2009):** Qualitative and quantitative methods were used to understand the prevalence of anal sex among FSW in intervention area, condom and lube use during the practice, and what drives the practice.

• **Flood Impact Study (2009-10):** Late 2009, Kurnool witnessed massive floods and it was feared that this might lead to migration of the sex workers, impacting the HIV prevention programme. Focus group discussions and in-depth interviews with the community members were done to understand if floods contributed to HIV vulnerability.

• **Polling Booth Survey (2010):** Condom usage information among KPs was collected using Polling Booth Survey to reduce individual bias when an individual is asked direct questions on sensitive issues.

• **Social Network Analysis (2009):** SNA was undertaken annually in the second phase to update demographic profile of the KPs for their risk assessment and categorisation so as to make necessary changes to the programming, if needed.
- **MSM Study (2009-10):** Dr Chakrapani conducted a qualitative study among MSM to understand the risk behaviour, community dynamics and health needs among MSM to improve their engagement in the programme.

- **Communication Needs Assessment Study (2009-10):** By New Concept Information System.

- **Trends of Sexually Transmitted Infections (STI) among Key Populations Attending Mythri Clinics of Alliance India in AP (2009):** The CMIS data on STI (monthly reports of NGOS) was compiled and analysed to understand the STI epidemiology in Alliance India intervention areas.

- **Mystery Client Survey (2010):** A group of investigators were selected and trained on essential sex worker package and clinic standards. They then visited the randomised clinics pretending to be the new KPs. Feedback was taken from them on return, collated and analysed.

- **Understanding Referral Systems of Mythri clinic (2010):** The study objective was to understand the gaps in the system and take corrective action to strengthen the system.

- **Prevalence of STI among FSW while Supporting Labs with ESCM (2011):** In a bid to strengthen the lab services in the state, linkage was established with medical colleges. Mythri doctors and ANMs were trained on taking culture samples from and samples were transported to the medical colleges.

The results of the studies above as well as lessons from programme implementation were shared with the NGOs, concerned communities as well as disseminated to wider audiences including SACS, state and district health authorities, and other organisations working in the field of HIV through state level dissemination meetings.

**Peer-reviewed Journal Articles**


- Alteration in sample preparation to increase the yield of multiplex Polymerase Chain Reaction assay for diagnosis of genital ulcer disease. Rao G, Das A, Prabhakar P,


**Case Studies**

- *Mythri Mainstreaming Model – Alternate STI service delivery model through Public healthcare facilities (2010).* Published by India HIV/AIDS Alliance.


- *Understanding Barriers and Challenges in SRH (2011).* Published by India HIV/AIDS Alliance.

**Manuals**

- *Clinical Management of Sexually Transmitted Infections in Resource-Poor Settings – A Comprehensive Guide for Clinicians:* The manual is a resource book for clinicians detailing the syndromic case management including diagnosis and treatment, STI clinic systems, data collection and reporting.
- **Setting Up and Managing Sexual Health Clinical Services in Resource-Poor Settings – A Comprehensive Programmatic Guide for NGOs:** It guides the programme managers on the infrastructure, equipment, selection of location and medical doctor, procurement systems and quality of services.

- **Peer Educator Manual:** A four day training manual for peer educators and outreach workers that deals with thematic knowledge as well as communication skills.

- **Procedure Manual for ANMs:** This is a hands-on training manual for the STI clinic nurses with modules on STI counselling and management of clinic systems (documentation, infection control, procurement of kits). (Translated in Telugu).

- **HIV/AIDS Advocacy Manual:** Telugu manual used for training the CAG members on basics of collective advocacy skills.

- **Essential HIV treatment and Care in Primary Care Setting:** A Comprehensive Guide for Clinicians and Healthcare Workers. Four day module to equip the medical officers with knowledge for identifying and managing basic OIs, primary prophylaxis for OI, and side effects of ART.

- **A Trainers Manual on supportive supervision:** To strengthen outreach for TOT involved in HIV prevention program of India HIV/AIDS Alliance.

- **Legal Literacy Manual:** A job aid for the ORWs to educate the community members on legal rights. (Telugu).

- **Police Advocacy Manual:** Used to sensitise the Police personnel on HIV and key populations to prevent raids and unwarranted arrests of the sex workers and MSM.

- **Monitoring and Evaluation Manual:** The data collection formats for outreach and clinical services, project reporting formats and indicators and milestones for the project to train the MIS officers.

- **Training manual for Care and Support and Positive Living (Telugu).**

- **Positive Prevention module for Female Sex Workers (English and Telugu).**

- **Training module on community mobilisation an community led structural interventions.**

- **Sexual and Reproductive Health Module:** For the ORWs working with FSW (Telugu).

- **Modules on Community Mobilisation (Telugu).**

**Books/Flipbooks**

- Outreach messaging
- STI booklet
- Booklet on outreach strategy
- Two flip books for IEC for FSW and MSM
- Legal literacy

**Posters and Flow-Charts**

- Flow charts and posters developed to explain various clinic protocols
- Flow charts for syndromic case management of each STI syndrome as per NACO protocols
- STI syndromes and their treatment using color coded packs
- Asymptomatic treatment protocols
- Anaphylaxis management
- ICST treatment flow chart for syphilis
- Syphilis screening procedure
- Referral from Mythri clinic to RNTCP diagnostic and DOTS centers
- Post exposure prophylaxis
- Co-trimoxazole prophylaxis for PLHIV attending the Mythri Clinic
- Comparative chart of Alliance India and NACO color coded packs to facilitate transition
- Essential Sex worker Package
- Posters for display in DIC (Patient Rights, Confidentiality Statement)
- Roles and Responsibilities of PE and ORW

**Audio-visual Aids**

- Nrityanjali audiovisual (AV) CD for songs on HIV Prevention
- AV CD with songs on condom promotion from HANDS project, an implementing partner
- AV film on clinic system management – a resource for ANM
- AV film for promotion of internal examination for STI
- Vijayam Kosam – a community production on collective advocacy by the community to partner with local CHC for STI services
Chapter 9

Challenges and Key Learnings

Frontiers Prevention Programme

- Identifying NGOs for implementation of programme: Identifying the right organisation with experience in HIV out of a pool of more than 800 NGOs working in the state was a challenge. A stringent process was followed for NGO selection and the process was outsourced to external consultants to ensure roll out happened at the earliest.
- Low HIV experience of NGOs: The local NGOs had extremely limited capacity to implement prevention programs and to work with the key populations, thus requiring intensive capacity building. This resulted in increased time taken - both to start up intervention and then to ensure that these are brought up to the minimum standards/quality.
- Stakeholder management: Apart from LEPRO India, all three offices of Alliance (Brighton, Delhi and AP) were involved in management and so were APSACS and BMGF. There was confusion in roles.
- Motivation to work with key population members: Attitudes towards sex workers and people with alternate sexualities among the general population made it difficult for the NGOs to recruit committed and capable staff in the establishment phase. Moreover, in some NGOs, the board members were reluctant to take up this project.
- Trust building: Working with a community with low self-esteem and poor trust in their peers, it is important to handle the community dynamics with care and ensure transparency. Having community centric programme and systems to have participatory processes (eg community representative on NGO recruitment panel), helped build confidence and trust in the community.

**Outreach**

- Illiteracy of key populations was the greatest hindrance for training them on outreach messaging and usage of IEC material for the purpose.
- Getting a safe space for DIC for the key populations especially for the MSM populations was tough.
- Documentation and reporting of implementation was a challenge.
- Having outreach teams from within the community helped in early identification of the KPs and makes it easier to reach out to all. Moreover, being from within the community, they can better understand the issues and barriers in behaviour change and address them if possible, or bring those to the notice of programme staff for further action.
- Having peer educators from the same category (typology) of KPs ensured the reach of services completely to the respective communities.
- Implementation of outreach according to a micro plan ensured reaching out to all the KPs within that particular hotspot/site with messages specific to the individual’s need.
- At DICs being a safe space for the community was provided all the freedom and were encouraged to express their sexuality. That facilitated the community to spend more time at the facility and access all the services provided by the programme.

**Clinical Services**

- Mobilisation of KPs to STI clinics: In the initial phase, KPs did not want to come to the clinic due to stigma attached to STI/HIV. Various mobilisation strategies had to be adopted to bring them to the clinic and then ensure they avail the services regularly. The most important of those were Mythri condoms and provision of general medicines.
Incentives like lottery system, addition of SRH services, best performing ORW and PE, and organising festivals in DIC helped in sustaining the clinic flow.

- Attitude of clinic staff: In initial phase, the attitude of some doctors towards KP at times was discriminatory or condescending. The training of medical officers therefore included training on KP issues, sex and sexuality, eliciting sexual history, etc. Moreover, placing a clinic administrator from the community helped normalise the clinic environment. Issues of discrimination or lack of sensitivity by the clinic staff was addressed by CA and CSRC through KP interviews. There were instances of doctors being changed due to their attitude issues and clinic timings or location revisited if inconvenient to KPs.

- Partner treatment: Partner treatment, essential for STI management, was a big challenge and remained very low. Many NGOs tried meeting with regular partners and/or giving the STI pack for partner treatment to KP. However, partner tracing remained elusive due to confidentiality issues.

- Internal examinations: Internal examination for the KPs attending the clinic for RMC for cases that had no STI symptoms was not accepted by half the KPs. The problem was compounded by the reluctance of medical officers to conduct vaginal examinations as many doctors were not comfortable using Cusco's speculum. Repeated counselling by clinic counsellor showing the speculum to the KP and trainings of medical officer helped promote internal examinations.

- Syphilis and HIV test: The KPs were reluctant to test for fear of getting detected positive and losing their business. Initially when ART was not so commonly available, a positive HIV test was considered death sentence. Additionally, although HIV test was available through referral, KPs did not wish to go to ART centers. As for syphilis, there was reluctance to provide venous blood sample. These barriers were systematically addressed through education, pre-test counselling and explaining the concept of positive living and positive prevention. A community person was placed at ART center to facilitate the visit to ART center.

- Supportive Supervision to all clinics: Due to geographic spread of TIs, visiting every clinic once a quarter was a challenge. The technical team had to prioritise the clinics based on need.

**Community Mobilisation and Advocacy**

- Facilitation of capacity building of NGOs, CBOs and service providers on an ongoing basis: While in initial years, major challenge for the Alliance India was to ensure that the NGOs, who were new to the issue of HIV and key populations, understand the key issues on HIV/AIDS, and are sensitised towards key population (KP) issues, develop the right attitude and approaches, are aware of KP led programming and rights based approach to development. These were addressed through:
  - Planning a variety of capacity building programmes, including workshops, immersion programs through exchange and exposure visits, hands-on site level training and provision of technical support.
Empowering Key Populations for Sustainable HIV Prevention

- Technical support grants with organisations like DMSC to provide hands on support to NGOs.
- Identifying and involving local resource persons for building a local resource pool (though found to be extremely difficult to get people with local language skills and training skills).
- Invoking TSS and other KPs for capacity building programs.

- Consolidation and fine tuning of interventions in the sites: Besides capacity building workshops, many of the NGOs required hands-on support in improving the quality of interventions and strengthening community mobilisation and social capital building. Visit of Project Officers of Alliance India and other technical support team members ensure that they are provided with sufficient support. However, maintaining momentum and quality while scaling-up to ensure sustainability and impact was still a challenge.
- In more than 80% of the sites, the KP were extremely scattered (street based or secret) and it was difficult to get a cohort of more than 5-10 KPs in one hot-spot, making outreach and community mobilisation extremely challenging, energy intensive and time consuming.
- Strengthening the advocacy skills and knowledge of the community representatives at all levels has also been a challenge.
- Though the CBOs became functional, their governance remained to be a critical issue. The EC members had limited understanding of managerial, technical and financial systems. Moreover, there were leadership conflicts and minimal efforts to develop second line leaders. The same concerns have been highlighted during the study of CBO’s CB Needs Assessment. In order to mitigate the concerns pertaining to the governance and other such issues, Alliance India organised trainings on organisational development, leadership skills and governance to build their capacities for improved performance.
- CBO nurturing also suffered due to lack of support from the NGOs implementing the TIs due to their vested interest. The handholding support that was expected from implementing NGOs was missing.

**Transition**

- Alignment with NACP III proved to be the biggest challenge to transition. Although on face of it, TI management in NACO system looked very similar (there were intense inputs given by Avahan during development of TI guidelines for NACP III), many systems remained different and TIs had to unlearn what they learnt during last five years and start afresh.
- The state did not have enough staff to provide regular supportive supervision and data monitoring inputs to the NGOs. Intense post-transition support was therefore extended from six months to one year.
- Staff turn-over: There was turn-over in NGO staff, especially at project coordinator level due to static or lower salaries and also due to perceived uncertainties following
change in management from Alliance India to SACS. The turn-over in ORW and peer educators following alignment with NACP III operational and costing guidelines was witnessed by all implementing partners.

- Building and sustaining capacities of the communities for transitioning TIs to CBO was a big challenge, especially at a time when all TIs required additional handholding due to staff changes brought in by alignment process.
- Sustaining the momentum of regular prevention services, especially mobilisation to the clinics was also a challenge.
- The transition process proposed a very close coordination and jointly working with the government, using the guidelines and systems for ensuring that the preparations were well in place for handing over. The key component of this process was maintaining good and consistent dialogue with the SACS and the implementing NGOs.
- With all the TIs to be handed over to the government in a phased manner, it was important to align with NACP III guidelines, changing the costing and staff structure of all NGOs. Moreover, there was no budget for general medicines which impacted the clinic flow. For a smooth transition and to minimise impact on the community, it would be ideal if the cost reductions are done in phases.
- Also it is important that the best practices and innovations are timely shared to be incorporated in government programs. Although some practices were taken up, many more like individual tracking, CMIS, MMM model, SRH and care and support integration were not included.
Achievements of Avahan

In ten years of implementation of Avahan, there has been significant improvement in the key indicators of the Avahan programme. Major accomplishments of Avahan are mentioned below.

- **Coverage and Infrastructure:** Alliance India through implementing partner NGOs reached out to 76,822 KPs (49,776 FSW, 23,281 MSM and 402 IDU) in 141 sites across 14 districts of Rayalseema and Telengana region of Andhra Pradesh. The HIV prevention programme was implemented by 46 NGOs through 40 interventions. A total of 155 drop-in-centers were established to provide safe space for the KPs. A network of 1,421 peer educators and 415 outreach workers was created from within the community. STI services to KPs and their partners were provided through 152 clinics, static, satellite, referral to both private and public healthcare facilities, and outreach/mobile clinics. Laboratories were set up in 16 Mythri clinics for enhanced syndromic management in 2005 and 2006.
- **Decrease in Risk Behaviour and Improved Health Seeking Behaviour:** Over the project period, 127,399,945 free condoms were distributed. Comparing the results of BTS-I (2009) and BTS-II (2011), the number of respondents using consistent condom with commercial clients increased from 95.2% to 97.5% among FSW and from 74% to 78% among MSM. The proportion of FSW reporting use of condom with their regular partner also increased from 63.5% to 76.4%.

- **Reduction in STI Syndromes:** On an average, 26% of the total population attended the STI clinics every month for regular monthly check ups. There was an average of three clinic visits per KP per year and whereas 76% of the registered KPs attended the clinic at least once a year, the proportion increased to over 90% in the second phase. During all these years, syndromic case management for different STI syndromes was received by 57,693 KPs. Percentage of KPs reporting STIs showed a steady decline from 2004 to 2011.

- **Decrease in Overall STI:** While STI symptom visits decreased from 28% in 2006 to 2% in 2011. The number of MSM attending clinic every year increased from 6,000 to 16,000 during this period. There was a significant decrease in genital ulcerative disease (GUD) among MSM/TG, from 16.4% to 9% in the last five year period of Avahan. Declining trends were seen in STI symptoms among FSW as well. As the number of FSW availing STI services increased from 9,500 in 2006 to 37,716 in 2011, proportion of visits for STI symptoms decreased from 35% to 4.5%. Similarly, the proportion of sex workers reporting STI declined from 58% to 13.5%. The GUD decreased from 7% in street based sex workers and 4.5% in home based sex workers in 2006 to 2.2% and 1.5% in 2011 respectively.

- **Syphilis:** From 2008 onwards, every KP was tested for syphilis at least once during a year. During the project period, a total of 2,259 KPs were found reactive for syphilis of the 63,009 KPs tested and treated with inj. benzathine penicillin. Reactivity rate of syphilis decreased from 3.8% in 2007 to 0.2% in December 2010.

- **Hepatitis B:** In addition to syphilis, 11,434 KPs were tested for Hepatitis B (HBsAg) as well in the Mythri clinics and 238 KPs were found positive for Hepatitis B Antigen, with reactivity rate of 2.08%.

- **HIV:** From the year 2009 onwards, approximately 60% of KPs were tested for HIV every year. By 2011, over all 2,550 KPs were detected HIV reactive and 1,598 were linked with ART. Analysis of data showed HIV sero-conversion rate of 0.89 per 100 PY. The HIV prevalence among MSM and FSW in the state as per NACO HIV Sentinel Surveillance reduced from 16.97% and 16% respectively in 2004 to 10.14% and 6.86% in 2010.

- **CBO Formation:** A total of 115 CBOs were formed of which 67 were registered with a membership of 24,349 KPs.

- **Capacity Building:** Over 2,000 PEs and ORWs, approximately 100 Clinic Administrators, 100 counselors, 200 ANMs, 200 doctors have been trained in their respective fields. To promote mainstreaming of STI services, another 500 doctors and paramedical staff from government hospitals (PHC, CHC, area hospitals, and DSRC) were trained on syndromic case management of STI.
• **Reduction in Violence:** To address the issue of violence at hotspots by local goons or the police, and for other advocacy initiatives, 376 community-led Core Advocacy Groups (CAG) and 1,013 24-hour Crisis Response Teams (CAT) were established in 13 districts during 2006 and 2007. By December 2011, of 1,431 violence incidents reported to crisis teams, 1,372 had been responded to within 24 hours. While in 2010, police was the perpetrator in more than 50% cases of MSM respondents who reported violence, it decreased to 15% in 2012.

• **Sharing Learnings in Different Forums:** Team actively participated in various national and international conferences, workshops and state and national level meetings to present the learnings from the project. Since 2005, Alliance India presented their work through 15 posters or oral presentations. In addition, there have been publications in peer reviewed journals.

• **Successful Transition of Programme to Government and Communities:** All the TIs have been successfully transitioned to APSACS as planned and the post-transition technical support also completed by March 2013. The TI performance indicators at the end of post transition support period have been sustained, maintaining monthly outreach at 96% of active population and quarterly RMC of 90%.
Our Avahan Team

Programme Leadership

Dr P Prabhakar  Shumon Sengupta  P Shailaja
T Bhaskaran Menon  D Dhanikachalam  S V Sreeram
R S Sharat  Prabhakar Varma  Chulani de Zoysa

Team

A P B Mallick  Lorraine Hutt  Ramachandra Rao Nishtala
Anne Anish  M B Giridhar Goud  Ramana Murthy S V
Aravinda Devi K  M Balakrishna Prasad  Rambabu K
B Madhavi  M Kishore  Sandhya Srinivasan
Dr B Ravi Kumar  M Krishnaveni  Dr Saroj Tucker
Basavaraj I Hebbal  M Rajeshwari  Dr Satish Kumar K
Bilavath Dhenuka Naik  M Srinivasa Rao  S J Prasanth
Chintamani Mahapatra  M Jyotsna  Dr S Ratna Devi
Dr Deepa Haritha V  M Ravikanth  S Srinivas Goud
Dr Devender L Delhikar  Madhavi Ganapathi  Sanjib Gouda
Dr Dilzith Arora  Mustaq Ahmed  Dr Suresh Babu K
D Nirmala  N Nelson  Shravan Kumar
G Selvaraj  Nagendra Varada  Siddhartha Das
G M Sastry  P Martin  Sri Tulasi
G P Tiwari  P N Srinivas Rao  Subramanyeswara Rao C
G Swathi  P S Renuka  Suresh Pakki
Hemanth Kumar Telkar  P Santhi Sagar Rao  T Maheshwari
Jennifer Mathew  P Srikar  T Maheshwari
Jessinda Mathew  P Swarup  T R Ramachandran
K B Saraswathi  Dr Pramod Gautham  Dr Vaishali Y Birhade
K Satish Kumar  Prasenjit Sarkar  Visweswara Rao
K Rambabu  R Ramakrishna  Dr V Shanthi
Krishna Gayathri  R Shanti Thumati  Dr Vijay Kiran
Kumar Nagarajan  Raghu Kumar M S  Dr Vijay Kumar
L Narendra Nath  Rajesh Divakaran  Vunnava Janardhan Rao
L Supriya  Rama Siddella

National Leadership

James Robertson  Shaleen Rakesh  Dr Balwant Singh
Rajan Mani  Alexander Mathieu  Dr Asha Rao
Sonal Mehta  Fiona Barr
India HIV/AIDS Alliance

Headquartered in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national programme, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations affected by the epidemic. The organisation’s programmes focus on those most vulnerable to HIV, with a particular emphasis on marginalised populations including men who have sex with men (MSM), transgenders, hijras, sex workers, injection drug users (IDUs), at risk youth and women, and people living with HIV (PLHIV).

Published: June 2014

© India HIV/AIDS Alliance

Information contained in the publication may be freely reproduced, published or otherwise used for non-profit purposes without permission from India HIV/AIDS Alliance. Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV status.

Images © Prashant Panjiar and Peter Caton for India HIV/AIDS Alliance

Design: Sunil Butola, India HIV/AIDS Alliance


India HIV/AIDS Alliance
6 Community Centre, Zamrudpur
Kailash Colony Extension
New Delhi 110048

Regional Office
Sarover Center
5-9-22 Secretariat Road
Hyderabad 500063
Andhra Pradesh

Follow Alliance India on Facebook:
https://www.facebook.com/indiahivaidassandraiance
Empowering Key Populations for Sustainable HIV Prevention

Avahan in Andhra Pradesh
2003-2014