Focussed prevention in Andhra Pradesh

- 13 districts covered
- 24 NGOs contracted
- 73 sites covered (26 FPP and 47 AI)
- 352 peer outreach workers and 128 peer educators trained and deployed
- 51 static ‘Mythri’ clinics operational
- 9 mobile clinics operational
- 41 doctors, 40 paramedics, 19 KP clinic administrators, 154 non-KP NGO staff deployed

- 65 KP managed drop-in centres operational
- 22,190 SW, 12,074 MSM, 524 IDU and 3928 PLHA accessing services
- 19,602 STIs diagnosed and treated
- 55,07,773 condoms distributed
- CBOs formed: 17 by sex workers, 14 by MSM, 5 by PLHA
- 19 training programmes / workshops conducted
- 664 staff (including KP representatives) trained
The vision of the International HIV/AIDS Alliance is of a world in which people do not die of AIDS.

For us, this means a world in which all human rights are respected, where every person can live with dignity, and where communities have brought HIV/AIDS under control, preventing the transmission of HIV, accessing and providing care and support, and alleviating the impact of the epidemic.

WHAT WE ARE

Established in 1993 (with a Secretariat at Brighton), the International HIV/AIDS Alliance focuses on mobilising and strengthening community responses to HIV/AIDS. This approach is based on the belief that those at the frontline of the struggle against HIV/AIDS must have the resources to take on the challenges the epidemic presents.
The mission of the International HIV/AIDS Alliance is to reduce the spread of HIV and to mitigate the impact of AIDS.

The Alliance is committed to preventing HIV infections, facilitating access to treatment, care and support and mitigating the impact of AIDS, through local leadership, commitment and responsibility, supported by knowledge, learning and resources drawn from local and external sources. The Alliance prioritises the meaningful involvement of people living with HIV/AIDS in all aspects of our response to the epidemic.

We prioritise work with Key Populations (KP) in both high and low prevalence countries, and seek to develop partnerships with them. By key populations we mean those most likely to affect epidemic dynamics and/or most affected by HIV/AIDS. Our emphasis is on strengthening of “social capital” within these groups by supporting them to organise, manage and sustain their own CBOs to work with their peers.
Since its establishment, the Alliance has worked with community organisations from over 40 developing countries. By 2005, 12 years after it was initiated, it had long-term programmes in Brazil, Burkina Faso, Cambodia, Ecuador, India, Madagascar, Mexico, Mongolia, Morocco, Mozambique, Nigeria, Philippines, Senegal, Thailand, Ukraine and Zambia. The Alliance had also successfully initiated programmes in China and the Eastern Caribbean, as well as project activities in Zimbabwe and Myanmar, besides others through the Alliance’s regional programme activities. The Alliance has provided financial support to over 2,500 projects, implemented by over 1,800 community and faith-based groups. At least a further 5,000 groups with project financing from other sources have been extended technical support.
The International HIV/AIDS Alliance started its partnerships in India in 1999 with the establishment of its country office in Delhi. In 2000 the Alliance and its Lead Partners (LP) initiated the Home and Community Based Care and Support Programme, with the financial support from European Union and Abbott Laboratories Fund Step Forward Programme. This programme aimed to mobilise and provide care and support to PLHA and their families in three states. This programme has enabled Alliance India and its three Lead Partners provide organisational and programme development support, onward granting and technical support to 37 implementing NGOs (INGO) to deliver effective, quality low-cost home and community based care and support to PLHAs, children and family members.

Alliance’s lead partners:
*Vasavya Mahila Mandal* (VMM), Andhra Pradesh
*MAMTA Health Institute for Mother and Child* (MAMTA), Delhi
*Palmirah Workers Development Society (PWDS)*, Tamil Nadu

Other state level partners:
* LEPRa Society* - District based NGOs in Andhra Pradesh
* Social Awareness Service Organization* (SASO), Manipur
FOCUSED PREVENTION ON HIV/AIDS IN ANDHRA PRADESH

Estimated HIV/AIDS burden - AP
- Reported AIDS cases 15410
- Diagnosed HIV Cases 37,127
- Estimated HIV Infection 4,73,250 - (1.25%)

Alliance In ANDHRA PRADESH
In Andhra Pradesh, across the Rayalaseema and Telangana regions, Alliance is providing strategic and programmatic leadership for implementation of the:

- **Frontiers Prevention Programme (FPP)** in 26 sites
- **Avalahan (India AIDS Initiative)** in 47 sites

The above projects are supported by the Bill and Melinda Gates Foundation, under the overarching guidance of the AP State AIDS Control Society. Alliance is engaging with the Key Population (KP) groups, such as Female sex workers, Men who have sex with men (MSM), People living with HIV/AIDS (PLHA) and Injection Drug Users (IDU).

Package of interventions and proposed impact:

**INTERMEDIATE OUTCOMES**
- Enabling environment
- Service and commodity provision for KPs

**PURPOSE IMPACT**
- Empowering for prevention for KPs
- Decrease in KP risky behaviour
- Decrease in KP STI prevalence
- Decrease in HIV incidence amongst KPs
- Decrease in HIV incidence in site

**GOAL/IMPACT**
- Decrease in KP risky behaviour
- Decrease in HIV incidence amongst KPs
- Decrease in HIV incidence in site
Under the Frontiers Prevention Programme, in addition to sex workers and MSM, the key population groups also include IDU and People Living with HIV/AIDS. The FPP was initiated and driven by key community representatives with NGOs subsequently supplementing community led social capital building initiatives with STI services and condom promotion. In the Avahan, the process was initiated and driven by contracted local NGOs, who subsequently brought in community representatives to promote social capital building.
PROGRAMME COMPONENTS

Community Mobilisation, Social Capital building and Community Led Structural Interventions(CLSI): this includes

- Intensive community mobilisation through Participatory Site Assessments (PSAs).
- Collectivisation, promoting mutual support, networks and solidarity (social capital) among KPs and leadership training for KPs.
- KP led enabling environment activities based on respect, recognition and reliance (3-R approach).
- KP led risk reduction skills building activities.
- Capacity building of KPs to address structural determinants of inequality, marginalisation and vulnerability (including violence reduction), risk and impact.
- Collective mobilisation of KPs to Influence and inform the policy environment through multi-tier advocacy and creation of a supportive environment.
- Initiatives with gatekeepers to build support for risk reduction in KPs.
- Provision of safe space for KPs to meet, bond and work together.
- Strengthening NGO capacity to work with mainstream KPs within NGO organisational and governance structures.
Specific interventions for community mobilisation adopted by Alliance partners:

At the community (micro) level community mobilisation is being attempted by:

1. Involving KPs from step one of the Project Cycle and building self-esteem of marginalised groups
2. Addressing the individual, promoting self esteem (through the 3 - R approach) and awareness and developing a shared understanding on vulnerability to STD/HIV
3. Enabling and supporting individuals and groups to relate to the broader social context and based on their understanding, to communicate, negotiate, advocate and push for change with gatekeepers and other bodies of control within and outside their communities
4. Facilitating the formation and registration of self-help groups and formal networks
5. Facilitating the acquisition of bank accounts
6. Organising workshops for occupational skills building and violence reduction
7. Developing linkages / affiliation with and seeking support from sex workers/MSM/PLHA collectives and movements across India.

At the structural level, the interventions include:

1. Formation of 3 committees in every NGO, with a minimum 3 KP representatives in each committee:
   - Programme monitoring and review committee
   - Advocacy and ethical committee
   - IEC committee
2. Induction of KP representatives as staff members of NGOs at supervisory levels and not just as part time peer educators
3. Adoption of a code of conduct for NGOs that includes good practice to be encouraged and bad practice to be eliminated over a period of time. This covers issues around discrimination, stigma, denial, democratic functioning, respect, recognition, reliance and being non-judgmental and non-moralistic
4. Constitution of a community advisory committee (to meet every 6 months at Hyderabad) to advise the Alliance team on issues of community mobilisation, social capital building, empowerment, structural interventions and provide direct community feedback on quality of services
5. End of the year review to be undertaken with each NGO and KP representatives.
Participatory Site Assessment (PSA)

Participatory site assessments have been carried out across 26 sites - a process that involved trained members of key population groups working in teams alongside researchers and service providers. The aims were to:

- Estimate the size of key populations in each site
- Characterise the key populations to facilitate subsequent programming
- Identify HIV-related needs, existing HIV programmes and key gaps
- Facilitate site and population specific intervention design with members of the key populations
- Begin the process of mobilising key population groups for HIV/STI prevention.

In phase one (done in 14 FPP sites and 12 Avahan sites), a range of participatory, visual tools were used to generate qualitative and quantitative information - to estimate numbers in different key population groups, to identify subgroups of key populations, to identify patterns of key population mobility, to locate existing service provision, and to discuss vulnerability factors. In phase two (done in 14 FPP sites), 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. The community-led qualitative analysis of the context of marginalisation, vulnerability and high-risk sexual behaviours was mapped against the availability of existing health services (including availability of condoms and the presence of STI services) and other social services. During this process, six key population representatives were provided two week-long training courses on STI/HIV/AIDS and the use of participatory tools.

The participatory assessment - while being an important means for designing an intervention - was also an end in itself, in that it was an empowering process that entailed reflection and analysis, leading to community mobilisation and a desire for action. Hitherto marginalised communities like sex workers for the first time experienced being treated as equals-with dignity and respect by "outsiders", which led not only to an increase in self-esteem but also to a motivation for self assertion.

At the end of the PSA process representative from each of the communities of sex workers, men who have sex with men and intravenous drug users 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.

PSA as a process has generated a good deal of interest from a wide variety of groups, both for its potential to generate numbers and for its ability to mobilise key populations. Apart from scaling up the practice in Andhra Pradesh state in India, support for adapting PSA was requested from the Andhra Pradesh State AIDS Control Society and other grantees of the Avahan have used the PSA approaches and tools in their programmes as well.
Management of Sexually Transmitted Infections (STI), includes:

- Syndromic management of STIs coupled with counselling - strengthening clinical capacities and quality of services
- Enhanced syndromic management in 15 sites and presumptive treatment in all sites
- Project-owned clinics - Mobile and community based static
- Referral networks with STI service providers in the private and public sectors, including accompanied referrals
- Comprehensive training of service providers
- Integration with STI franchising programme to ensure minimum standards and quality control.

Behaviour Change Communication includes:

- Behaviour Change Communication through peer education, enabling strategies and other outreach strategies
- Using KP specific, cultural and gender sensitive IEC materials and strategies
- Using multiple and innovative channels for IEC, including folk arts and folk media
- Identification and capacity building of peer-educators for outreach work
- Promotion and skills building for negotiating safer sex and using condoms and lubricants.

Community Led IEC development - Best Practice from the Frontiers Prevention Programme (FPF)

A five day IEC development workshop was organised attended by representatives of KPs - namely sex workers; MSMs; PLHAs and IDUs. 40 Participants received professional guidance on how to produce educational resources covering topics such as increasing awareness of HIV/AIDS, stigma and discrimination, gender and sexuality. The workshop gave KP representatives the training and opportunity to translate their experiential knowledge into messages that can be used to educate people (KPs as well as general population) on HIV/AIDS. In addition to promoting dialogue and solidarity amongst participants, it enabled them to reflect on their needs and concerns. A variety of high quality IEC materials were developed: that included flipcharts; posters; booklets; a mural; a calendar; a condom and lubricant packet; design, a performance and short films.

Key Populations' (KP) representatives were involved in designing their own IEC materials thereby moving away from being passive consumers of IEC to being both producers and consumers of information.

Evidence based rapid scaling up of interventions with Men who have Sex with Men (MSM) and Transgender (TG) persons in Andhra Pradesh.

It is estimated that around 31% of the sexual encounters between MSM in Andhra Pradesh include anal sex, out of which only 44% are protected - indicating high vulnerability of MSMs to STI/HIV/AIDS.

The Alliance's intervention program among MSM and TG in Andhra Pradesh focuses on provision of sexual health services that are designed and implemented through the leadership of MSM representatives. Since its inception in mid 2004, the programme has reached out to over 16,700 MSM who are accessing GB clinics and drop-in centres in 13 districts. So far, 445 HIV STIs have been treated. 170 HIV positive MSM provided with essential AIDS care and around 20,000,000 condoms distributed. Nine community based organisations (CBO) of MSMs/TGs have been formed. 114 MSM representatives have taken up programme management positions that were being held by professionals from outside the community.

Lessons learnt: Despite high levels of stigma and discrimination around homosexuality (including its criminalisation by law), the programme has succeeded in mobilising a large population of MSM over a short period and promoted health-seeking behaviour. The reasons attributed to this success are that the programme has used participatory approaches to first enable community representatives to map MSM networks, analyse their needs and subsequently design and lead in the implementation of the services.
Condom Programming:
- A combination of free distribution and social marketing managed by community representatives.
- Introduction of Mythri LU-CON packs (designed by the KP representatives) with two condoms and two lubricant sachets.
- Use of multiple channels for condom distribution at sites.

Capacity Building:
The main themes addressed by the capacity building strategy are:
- Conceptual and technical areas (Sex and Sexuality, basics of HIV/AIDS, focussed prevention, basic AIDS care, counselling)
- Cross cutting areas (Stakeholders analysis, advocacy, gender, ethical issues, KP-centric programming, rights based approach, structural interventions, occupation skills building)
- Programmatic areas (BCC/IEC, STI services, condom programming)
- Programme Management Areas (PSA, M&E/ indicators programme design and strategic planning)
- Organisation and institutional development (Financial systems, reporting systems, MIS, leadership, delegation, team work, conflict resolution, governance, network and alliance building)
Resources developed:

1. Community led STI service delivery: A comprehensive guide for NGOs
2. Clinical management of STI in resource poor settings: A comprehensive guide for clinicians
3. Condom Programming: A programme guide for NGOs
4. Peer education, outreach, communication and negotiation: Manual for Trainers
5. Community Centred Programming: Programme guide for NGOs
6. Stakeholders Analysis and Advocacy: Programme guide for NGOs
7. Legal literacy for Sex Workers: Flip book for outreach work
8. Flip Book on outreach with sex workers
9. Flip Book on outreach with MSM.
10. Essential AIDS Care: Manual for clinicians
11. Management Information System (MIS), Reporting and Monitoring: Programme guide for NGOs
12. Mythri - Lu-con Pack: KP designed condom-Lubricant pack for MSM and sex workers
13. For our sake - I and II: Multi-media pack in Telugu for Key Populations addressing issues such as STIs, HIV/AIDS, safer sex, stigma and discrimination, enabling environment and social capital building.
PROGRAMME STRENGTHS

The projects have achieved significant success in community response and coverage because of a close integration between primary prevention and community based care and support. The projects have consciously encouraged the community to articulate its priorities, be assertive and lead in programme design and management - embodying the community centered rights based approach. This has led to rapid scale up, community mobilisation and utilisation of project services.

The communities are being empowered to negotiate with different bodies of control. Spaces have been created within the institutional structures (through committees), in order to bring community perspective into the policy and decision-making levels. A state level sex workers' collective has been formed.

3. The continuous involvement of PLHA and others key populations like sex workers and MSM is critical to the rapid scale-up, success and sustainability of the programme.

4. Advocacy and community empowerment for addressing stigma and discrimination is key to the creation of an enabling environment.

5. It is very important to build capacities of health care service providers on user friendly treatment and care and support services.

General Lessons Learnt

1. It is important to focus on KP led process with KP representatives occupying positions of responsibility and spaces in decision making bodies.

2. It is important to integrate essential AIDS care within primary prevention programmes right from the beginning of the project.

Some of the hallmarks of the projects have been:

- Focus on key-population led processes and community led structural interventions.
- KP representatives in decision making bodies.
- KP managed drop-in centres.
- Combination of static, outreach and mobile clinics.
- Sensitive positioning and branding of clinics.
A socio-medical approach to STI service delivery enables the community to take the centre-stage of STI services and enables them to take over the management of all non-clinical aspects of STI services. This ensures that the STI services are accessible, affordable and user friendly.

In order to make STI services community centered and community led, periodic feedback is sought from the community on their satisfaction with the services and STI service review committees (with majority community representation) have been constituted at the site level for this purpose. A Community Representative is appointed as the Clinic Administrator (at par with the clinic doctor), who along with the doctor ensures that the services are responsive to community needs. To the extent possible paramedical staff and counsellors are appointed from the community.

As a result of making STI services community centered, quality of services has improved and patient flow has increased significantly. The programme has over a one and half year period treated 19,602 STI cases, out of which around 9% are ulcerative STIs. The use of 9 colour-coded STI treatment kits has ensured easy administration of treatment and compliance. It is important that the clinic premises are selected in consultation with the communities and branded sensitively so as not to create any stigma.

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**COMMUNITY ACTION**

**MYTHRI**

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**Community led rapid response in Chittur, Andhra Pradesh**

Since mid 2005, PASS, a local NGO has been implementing a focussed prevention programme in the Chittur district of Andhra Pradesh, with technical assistance from the Alliance. PASS, along with a few selected sex workers and MSM facilitated a participatory site assessment; mapped sexual networks; and supported community representatives design an intervention. Currently, 12 peer outreach workers, 2 doctors and 3 project staff have been inducted into the programme. The location of the project services (clinics and drop-in centres) have all been selected in consultation with the representatives of sex workers and MSM. 997 Sex workers, 329 MSM and 30 PLHA have been reached over a 9 month period; 2 clinics and 3 drop-in centres (identified and set up by the community) established. 393 STI cases treated, 40376 condoms distributed, 9 colour-coded STI kits successfully introduced to treat STIs and two collectives of sex workers and MSM formed.

KP programme planning and design have led to marginalized communities being treated with dignity and respect by “outsiders”, thereby increasing their self-esteem and motivating them for self assertion and action. Community led STI service appraisal and design have made services user friendly. The drop-in-centres have emerged as nuclei for community mobilisation and solidarity building. A combination of participatory and empowering approaches coupled with exceptional commitment by the local NGO has ensured rapid launch, scale up and high degree of community ownership of the project.

**Lessons learnt:**

1. Respect, Recognition and Reliance (RRR) on the community and building on the strengths of the community is important to promote greater ownership of the programme.
2. It is therefore important to involve community members in the project from the beginning - planning, implementation, monitoring, review and feedback.
3. Stakeholder analysis, sensitisation and involvement of different stakeholders plays an important role in effective outreach and scale up.
Recommendations:

1. Ensure that key populations (KPs) are involved in deciding the location of the clinic and while selecting project doctors, ask representatives of sex workers, MSM and PLHA to identify qualified local doctors who are friendly towards them.

2. Seek periodic feedback from the KPs on their satisfaction with the service providers as well as the clinic services.

3. Ensure that the clinic is operational as per the needs of the KPs in terms of timings, infrastructure, comfort, privacy and finally.

4. Ensure strong and organic linkages between the clinic staff and outreach staff to promote early reporting, compliance and partner management.

Issue:
Building social capital, transferring governance to the communities and engendering the rights-based approach to the AIDS response.

Description:
Since mid 2004 "Jagruthi" - a local NGO has been implementing a HIV/AIDS intervention supported by the International HIV/AIDS Alliance in Khammam district of Andhra Pradesh. Prior to the roll out of services, the process of community mobilisation and collectivisation was initiated by a team of 9 sex workers and 3 MSM peer outreach staff with Jagruthi taking a proactive role in building capacities of KP representatives. Over a one and half year period, 1564 sex workers and 544 MSM have been reached out with services; 1298 STIs treated; 5,30,525 condoms distributed; and two CGOs of sex workers formed. Inroads have been made into the sexual networks of secret sex workers - made possible since the services are accessible, welcoming, non-stigmatising and of high quality.

Reliance on and a genuine partnership with the community has raised the confidence and self esteem of many community members. The NGO leadership has consciously encouraged the community articulate its priorities; be assertive and lead in programme management - embodying the rights based approach. This has enhanced community ownership, translating into high levels of community outreach, condom distribution and STI treatment, potentially creating a significant and sustainable impact on the epidemic locally. Further, the formation of CGOs have led to a very high level of use of project services and improved health-seeking behaviours.

Lessons learnt:
1. Before the roll out of services, it is important to do a participatory mapping of the sex worker and MSM network through a process that allows the key population (KP) groups to map their distribution, analyse their problems and discuss possible solutions.

2. The roll out of services has to go in conjunction with a process of community mobilisation and social capital building that is built on community led structural interventions (CLSI).

3. The package of CLSI needs to include placing KP representatives in positions of decision making (within the NGO) and building capacities of KP representatives to form their own support groups and organisations.
THE FUTURE

Up-streaming Alliance’s work - influencing policy and wider environment:

- Alliance’s focussed prevention programmes in AP have produced spin-offs in the wider environment. The programmes have developed significant new knowledge, good practices and resources that other organisations in India are embracing.
- Alliance has also contributed significantly to policy and strategy development at the state, national and global level, based on the learning from the AP focussed prevention programmes. - At the state level, Alliance-AP has contributed to the design of the Project Implementation Plan (PIP) of NACP III, by serving as the convener of the working group in Targeted Intervention (Focussed Prevention).
- At the National level, Alliance-AP has served as a member of the working group responsible for designing the component of Targeted Intervention / Focussed Prevention under NACP III.

- At the global level, Alliance-AP has participated and carried learning from programmes in AP to the ‘3-Ones’ consultation in Rio De Janeiro and at the MSM and IDU round tables organised in Geneva and Chiang Mai respectively.

Alliance’s programmes (the FPP in particular) represent a move towards a new generation of focussed prevention effort that:
- Integrates prevention with quality AIDS care
- Builds on foundations of social capital building and structural interventions.
- The lessons emerging from our programmes have the potential to significantly enhance response to the epidemic across the developing world.

Looking ahead: Strategic priorities for the future:

- Scaling up the programme to ensure saturated coverage of Key Populations across Rayalseema and Telengana regions
- Consolidation and enhancement of quality across all intervention sites and in all programme components, in addition to developing learning centres
- Capacity building of civil society partners, including community based organisations and networks
- Advocacy with stakeholders in order to create an enabling environment for risk reduction
- Strengthening linkages among project partners and other stakeholders
- Capacity building and empowerment of Key populations, leading to phased transfer of programme governance to the communities - the natural owners of the programme.
Integrating vulnerability reduction, risk reduction and impact mitigation: Painting the Enhanced Response in Warangal

Since mid 2004, two NGOs - MARI (Modern Architects of Rural India) and LODI (a faith based organisation) have been implementing the Pioneers Prevention Programme (PPP), supported by the Alliance in Warangal district of Andhra Pradesh. A Participatory Site Assessment (PSA) was done to estimate key population (KP) numbers; identify vulnerability factors and explore HIV/AIDS risk factors. One trans-gender person, one MSM and two sex workers were inducted as Technical Support Staff (TSS). The two NGOs have been working in tandem with their KP representatives to provide a comprehensive package of services that included STI and essential AIDS care services (to reduce impact), BCC and condom programming (to reduce risk) and support to group formation, advocacy and linking up with other economic development programmes (to reduce vulnerability).

Over a one and half year period, the project has covered 1,704 sex workers, 2,887 NSM, 431 PLHA, treated 1,194 STI cases; distributed 1,78,709 condoms and mobilised 230 sex workers and MSMs into two community based organisations.

The approach of integrating prevention with care through a collaborative effort (of two organisations) has improved health seeking behaviour, built solidarity and provided psycho-social support. The partnership between a secular NGO, a faith based organisation has added a humane touch and ensured quality of services.

Lessons learnt:

1. With HIV prevalence rising, it is important to integrate care and support services, treatment access with primary prevention and engage PLHA in positive prevention.

2. The epidemic also requires collaboration between organisations such that they can pool in their comparative advantages and ensure a comprehensive package of services to the KPs.

3. It is important to adopt participatory approaches and empower KP groups so that they can take the lead in implementing the programme and.

4. It is important to ensure linkages and referrals with other services (including ART services) available in the public sector in order to broaden the response.

Spirituality, culture and sexuality: An ethnographic study of the use of mystical erotic rituals as a means of expression of same sex relationship between men in Andhra Pradesh, India.

Followers (mostly men) of a particular religious sect in Andhra Pradesh believe that they are “wives” of the Hindu God - Shiva. Every year, between February and October, around 50,000 followers gather in designated temples to get ritually married to Lord Shiva. During the three-dayuptil festival many devotees dress up and conduct themselves as women (often with the support of their wives, since it is considered sacred). Also during these festivities, around 50,000 men who have sex with Men (MSM) and trans-gender (TG) persons who are not within the sect, descend to these temple towns and engage in sex - a phenomenon that is accepted / tolerated by the local society. Many male devotees, while engaging in sacred rituals during the day, engage in sex with other men in the night. During these festivals, NGOs supported by the International HIV/AIDS Alliance organise AIDS awareness events, STI treatment camps, counselling sessions and distribute condoms and IEC materials.

Lessons Learnt:

1. Within a wider social environment of stigma and discrimination and a legal context that criminalises homosexuality in India, this particular sect and its annual mystical erotic rituals provide a safe and socially accepted space/outlet for the expression of homosexuality - including cross-dressing.

2. Under these circumstances, sexual activity associated with alcohol consumption tends to be extremely indiscriminate, and given that many MSMs are also married, such circumstances act as major trigger points for the transmission of the epidemic.

3. Events of this nature present very good opportunity to organise effective HIV/AIDS prevention activities. Therefore there is a need for partnering with the temple authorities to organise camps (probably just outside the temple premises) to provide counselling and STI treatment services and condom and lube distribution. In addition to awareness, generation through the use of local popular media like street theatre and folk performances. Finally, it is important to undertake sensitive ethnographic documentation and dissemination of such religious practices, in order to reduce stigma around homosexuality in India.
**VOICES FROM THE COMMUNITY**

**Yadamamma** says, earlier the community of Female Sex Workers (FSW) had difficulty accessing clinics for treatment. Here they feel more relaxed and are able to openly discuss problems; as they come here through us and because everything here is confidential. Once convinced they bring others. For street-based FSWs it is not so difficult to broach the topic directly; if they are secret FSWs from middle classes we approach the subject differently. We talk about general problems first and gradually open their eyes to STDs and HIV/AIDS. "We feel proud that we are not FSWs only; here we have a certain profile. We are working with the project. We are addressed by all as 'madam' and we feel nice about that. We feel we are not doing a job alone but also service to the society in some way".

**Kavita** a TG (transgender) Alec an outreach worker says, "some of us work secretly and hence we do not have direct access to condoms. A clinic such as this helps people like us."
Intervention with sex workers, street-based sex workers and MSMs in Jagalal and Metpalli: A success story of the rights-based approach under the Frontiers Prevention Programme

Since mid 2004 “REACH”, a local NGO has been implementing a HIV/AIDS intervention supported by the Alliance in Jagalal and Metpalli blocks. The interventions started with social capital building and subsequently complementing the social mobilisation process through provision of clinical services. The local NGO (REACH), contracted by Alliance, has taken a proactive role in empowering the community and placing the community in positions of decision-making. Over a one and half year period: 714 sex workers, 503 MSM and 210 PLHAs have been covered; 1,208 STIs treated; 2,600 condoms distributed; and a network for the caste based sex workers’ set up and it is CBO of MSM registered. The KPs are being empowered to negotiate with different bodies of control and spaces have been created within the NGO (through committees), in order to bring community perspective into the policy and decision making levels.

Reliance on and a genuine partnership with the KP groups has raised the confidence and self esteem of many KP members. This has enhanced community ownership, translating into high levels of community outreach, condom distribution and STI treatment, potentially creating a significant and sustainable impact on the epidemic locally. Community mobilisation, empowerment and the creation of enabling environments are therefore essential prerequisites for risk reduction.

Lessons learnt:
1. The first step in the project cycle needs to include a Participatory Site Assessment (PSA) process that will involve members of the KPs in collecting, analysing and sharing information, thereby creating a basis for design and implementation.
2. Subsequently, it is important to create physical and social spaces for KPs to meet, bond, discuss their problems and possible solutions and them and build capacities of KPs to influence the environment.
3. Finally it is important to facilitate the formation of collectives, built capacities on occupation skills and induct community representatives as staff members at supervisory and decision making levels.

Ahmed identifies himself as MSM. He has been an outreach worker with the Avahan project since the last six months now. He has had similar experience with other NGOs before this. But he points out the difference between his previous work and this one. In the present case there is a sustained interaction with KPs. "We bring people to clinics on a weekly basis here and for sustained treatment. In the year 2000 there was not much awareness about condom but today it is much better. We identify hot spots build friendship with the KP. The experience so far has been that whosoever has come to the clinic once never went back disappointed. We also take them to test centres for blood test if need be!"

Chakri, a Female Sex Worker (FSW) and outreach worker has been with the project since inception in 2004. "People did not believe us; initially, there was this attitude as to what new information would we give them. But with regular visits and consistent interaction, we convinced them about problems such as STDs and AIDS. Now they all understand; in fact they call us and ask when we would visit them next, and when they could come to the clinic again. This clinic provides monthly treatment for HIV/AIDS patients, unlike other such institutions."
Implementing NGO Partners:
Rural Education and Community Health (REACH)
Self Help Employed Welfare Society (SEWS)
Gram Nava Nirmana Samiti (GNNS)
Modern Architects for Rural India (MARI)
Lodi Multipurpose Social Service Society (LODI)
JAGRUTHI
Action for Girijan Development (AGD)
Human and Natural Resources Development Society (HANDS)
Centre for Rural Action (CERA)
Chaitanya Rural Education and Development Society
Achoni Area Rural Development Initiative Programme (AARDIP)
Mission to Encourage Rural Development in Backward Areas (MERIBA)
Serve Train Educate People's Society (STEPS)
People's Action for Social Service (PASS)
Rural Reconstruction Society (RRS)
Hyderabad Leprosy Project (HYLEP)
Action for Integrated Rural and Tribal Development Social Service Society (AIRTDS)
People's Action in Development (PAID)
People's Action for Creative Education (PEACE)
Adilabad Leprosy Project (ADILEP)
Action for Needy and Kindle the Illiterate through Action (ANKITA)
Chaitanya Educational and Rural Development Society (CERDS)

Our Partners in Andhra Pradesh:
LEPRA India, Hyderabad
AP State AIDS Prevention and Control Society, Hyderabad
Hindustan Latex Limited, Family Planning Promotion Trust, Hyderabad
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CARE, India
Partnerships for Appropriate Technologies in Health (PATH), India
Family Health International (FHI), India
International Centre for Research on Women (ICRW), India
Academy of Nursing Studies, Hyderabad
Duba Mahila Samravay Committee, Kolkata
Nrityanjali Academy, Hyderabad
Administrative Staff College of India, Hyderabad
Nizam's Institute of Medical Sciences (NIMS), Hyderabad
National Institute of Public Health, Cuernavaca, Mexico
Social & Rural Research Institute (A specialist unit of Indian Market Research Bureau), Delhi
TNS Mode Private Limited, Hyderabad
Humsafoor Trust, Bombay
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