PUBLIC HEALTH FOUNDATION OF INDIA

Alliance India HIV/AIDS

Strengthening Systems, Enhancing Capacities

Process documentation of the South-to-North Initiative in Bihar

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The cover page features a painting by sex workers from Madhubani, Bihar

Acknowledgements

The South to North Programme is implemented by the Regional Office of India HIV/AIDS Alliance, Andhra Pradesh (AP) in the state of Bihar with support from Bihar State AIDS Control Society (BSACS). Alliance aims at encouraging the replication of best practices by fostering and disseminating learning from the Avahan programme. The 'Best Practice' (BP) evidence generated by Avahan in AP, including the lessons learnt from routine implementation and management, contributed significantly to the NACP III. Bihar State was allotted to Alliance by the Department of AIDS Control (DAC) to extend technical assistance to BSACS with core objectives to strengthen key components of the Targeted Intervention (TI) programme (STI Services, Outreach and M&E) through establishment of five BP TI sites in Bihar and support other TIs. Five TI NGOs in five districts of Bihar (Begusarai, Madhubani, Muzaffarpur, Patna and Purnea) were selected as BP sites.

This process documentation captures initiation of the project, identification of best practice sites, exposure visit to AP TI sites, building capacities of staff for improvement of outreach, clinical services, and referrals to syphilis screening and HIV testing, and monitoring of progress from May 2013 to the present.

Dr Preeti Kumar, PHFI had suggested the idea of innovative process documentation with special emphasis on key take home messages for those organisations that would like to implement BP sites in low prevalence states. I wish to thank her for choosing Bihar S2N Project for this initiative and supporting the completion of the project. This work would not have been possible without the hard work done by The Communication Hub.

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I sincerely thank Mr James Robertson, Executive Director, India HIV/AIDS Alliance, for his encouragement and guidance throughout the implementation of the S2 N programme in Bihar. I also would like to thank Ms Sophia Lonappan, Senior Communication Officer for her support while preparing this report.

I trust that this document would be a ready reckoner for organisations that wish to begin developing learning/ best practice sites in India or in low income countries.

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Acronyms

AP	Andhra Pradesh
BGJAS	Bihar Gramin Jagrukta Abhiyan Samiti
BMGF	Bill & Melinda Gates Foundation
BSACS	Bihar State AIDS Control Society
BVHA	Bihar Voluntary Health Association
CBO	Community Based Organisation
CC	Core-Composite
CE	Community Educator
CQTM	Clinic Quality Monitoring Tool
DIC	Drop in Centre
FHI 360	Family Health International 360
FSW	Female Sex Worker
GPVS	Gram Praudyogik Vikas Sansthan
HASPKS	Harijan Adiwasi Shikshan Prashikshan Kalyan Sansthan
HRG	High Risk Group
ICST	Immunochromatographic Strip Test
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
L TI	Linked TI
M&E	Monitoring and Evaluation
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
ORW	Outreach Worker
PCC	Programme Coordination Committee
PD	Project Director
PE	Peer Educator
PHFI	Public Health Foundation of India
PM	Project Manager
PPP	Preferred Private Provider
Q TI	Quality TI
RMC	Regular Medical Check up
S2N	South to North initiative
SLP	State Lead Partner
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
TI	Targeted Intervention
TSP	Technical Support Programme
TSU	Technical Support Unit
WSW	Wama Shakti Wahini

Background

The Avahan India AIDS Initiative, started in the year 2003, is a large and ambitious HIV/AIDS prevention programme funded by the Bill & Melinda Gates Foundation (BMGF). Avahan has successfully built a large-scale HIV intervention programme in six states though State Lead Partners (SLPs) of India. The major states covered under Avahan are Andhra Pradesh (AP), Karnataka, Maharashtra and Tamil Nadu; they accounted for 83% of the country's HIV infections. Avahan SLPs have a long and comprehensive experience in HIV programme management in the southern states of India, with diverse capacities in multi-pronged HIV prevention and care programmes.

Considering their extensive experience and expertise in implementing and scaling up of successful prevention programmes, Department of AIDS Control (DAC) requested BMGF to transfer their learnings through these SLPs to the northern states of India. This initiative envisaged that an interactive and focused exchange of learnings will lead to increased knowledge and improved practical skills and capacities in the northern states. With the aim to share and disseminate the learnings and experiences and provide need-based technical assistance, 5 Avahan SLPs were identified by BMGF and NACO to support select states (Orissa, Bihar, Madhya Pradesh, Rajasthan, Chhattisgarh and Uttar Pradesh) in North India. This initiative is referred to as the South to North (S2N) initiative.

India HIV/AIDS Alliance, an Avahan SLP in Andhra Pradesh was requested to provide support to Bihar. After eight years of directly supporting Targeted Interventions (TI) in AP, Alliance India has now transitioned all TIs to Andhra Pradesh State AIDS Control Society and currently it provides post transition support to TIs to maintain intervention quality and coverage.

As advised by S2N, Alliance support to the Bihar State AIDS Control Society (BSACS) was with the objective to identify and strengthen learning sites, build capacities of other TIs through them and to build capacities of non - TI NGOs (ref box).

Objectives

The overall objective of the Technical Support Programme (TSP) is to strengthen key components of the TI programme (STI Services, Outreach and M& E) through Technical Support Units (TSU) in five (5) selected sites in Bihar

1. Development and Strengthening of capacity of 5 TIs as Learning sites/Best Practice sites
2. Learning sites/Best Practice Sites mentor other TIs in the District
3. Strengthening of Non - TI NGOs with a view to capacitate them for TI implementation

This document provides an overview of the processes of technical support and key learnings from the experience.

Understanding the Context

In 2011, Bihar showed an estimated adult HIV prevalence in the range of 0.20–0.27%. The total number of People Living with HIV (PLHIV) in India is estimated at 20.9 lakh (17.2 lakh–25.3 lakh), of which Bihar is estimated to have more than 1 lakh PLHIV. Together with West Bengal, Gujarat, Uttar Pradesh and Odisha it accounts for 29% of HIV infections in India.

The state has 7,794 (2011) annual new HIV infections among adults (15+ years). This is the fifth highest in the country preceded only by Andhra Pradesh (16,603), Odisha (12,703), Jharkhand (9,085) and Karnataka (9,024). There are an estimated 1.24 lakh PLHIV in the state. [1]

[1] *HSS 2011*

At the initiation of S2N (Jan 2013) there were a total of 30 TIs supported by the BSACS of which 5 were for Female Sex Workers (FSW), 10 for Injecting Drug Users (IDU), and 14 core-composite (CC). The population catered through the TIs was 33,388 and there were a total of 42 clinics for Sexually Transmitted Infections (STI) in the state. These TIs were managed by the TI Division at SACS. Unlike many other states Bihar TI division does not have the support of a state Technical Support Unit or a State Training and Resource Centre (STRC).

Getting Started

S2N sought to establish learning sites, develop their capacities to mentor other TIs as well as to capacitate Non - TI NGOs for TI implementation. In order to achieve the S2N objectives it was critical to not only understand the context of the state through review of documents and action plans but also to get nuanced understanding of the on-ground situation of TI.

Focussing on the existing TIs, Alliance worked towards developing an understanding of the status of each TIs, a process which would also support identification of learning sites. In consultation with BSACS an assessment of TIs was initiated.

A NACO **approved tool for TI assessment** was already in use under The National AIDS Control Programme (NACP). This tool outlines critical performance indicators (ref box) for TI as well as describes the context for performance such as availability of funds, drugs, condoms and capacity building, thereby providing a summary of performance and factors that have aided it.

Key questions guiding the baseline assessment

1. Does each Peer Educator (PE) have a list of the High Risk Groups (HRGs) for whom the PE is responsible?
2. Has the TI identified and reached the entire target population as defined in the contract?

3. Does each PE have details of transaction frequency and vulnerability for each HRG and are “at most risk” HRGs prioritised?
4. Did all HRGs receive condoms as per their requirement?
5. Do the HRGs have adequate condoms?
6. Are the HRGs using the condoms?
7. Did all IDUs receive needles/syringes as per their requirement?
8. Do the IDUs have adequate needles/syringes?
9. What is the return rate of needles/syringes?
10. Has the TI identified and established the PPP service model?
11. Is the project- owned clinic functional?
12. Do the HRGs access clinic services?
13. What percentage of HRGs (unique individuals) have accessed clinical service in the quarter?
14. What percentage of HRGs have accessed Integrated Counselling and Testing Centre (ICTC) services?
15. How is the TI ensuring the involvement of the community in the project monitoring?
16. How are the efforts for collectivisation of community?
17. What is the frequency of visit to the field by the project manager?
18. Does the TI have sufficient
    a. funds for carrying out the project activities?
    b. free condoms for distribution?
    c. colour coded drug kits for distribution among PPP?
19. Has the TI staff been trained on their programme components?
20. Have the Preferred Private Providers (PPP) doctors been finalised and trained?

Using this tool, assessment visits were conducted in all 30 TIs in the state. In many instances, the NGOs implementing TI extended their support to the visiting teams but in some others only a partial assessment could be conducted as NGOs did not have advance information about the visits and therefore were not

prepared for the review. Overall, the visits did provide critical insights into the functioning of TIs and the challenges they faced.

The assessment checklist was completed for 19 TIs, of which 10 TIs scored between 56-67%, 5 were between 46-55% and 4 between 34-45%. Major gaps observed through these assessments were: absence of line listing of the population; no prioritisation of PE outreach; absence of project- run clinics in some TIs; inadequate clinical instruments and equipment; STI drug stock out or expiry; condom stock out; limited and inadequate assessment of condom demand and supply; weak reporting as well as Monitoring and Evaluation (M&E) systems.

TI evaluation scores and reports for the year 2012 also served as a basis for understanding the status of TI. Along with the findings of the two assessments, Alliance India and BSACS also looked at a few additional parameters for identification of sites to be developed as Quality TI (ref box).

Considerations for selecting sites to develop Quality TI

1 Baseline assessment findings
2 TI evaluation grades
3 Outreach – Number of contacts made with the key population by ORW and PEs
4 Rates of Regular Medical Check- ups (RMC)
5 Project duration
6 Key population density of FSWs
7 Location – distance from other TI

The assessment findings and the ensuing discussions brought to the fore that the need of the programme in the state was to develop Quality TI which would create an environment conducive for the initiation and nurturing of innovative practices. A decision to focus support in this direction for TIs catering to FSWs was taken jointly by S2N and BSACS.

The five TIs selected to serve as sites for developing Quality TI were:

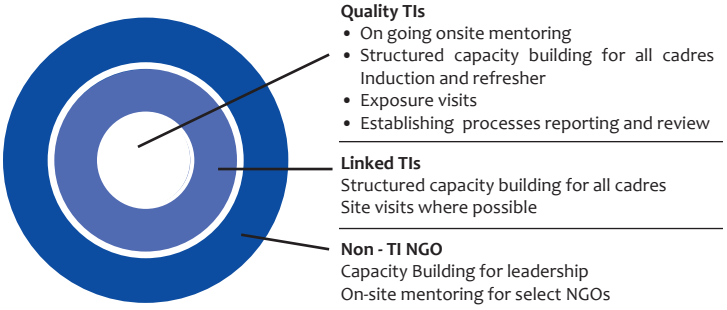
1. Bihar Gramin Jagrukta Abhiyan Samiti (BGJAS, Begusarai)
2. Gram Praudyogik Vikas Sansthan (GPVS,Madhubani)
3. Wama Shakti Wahini (WSW-Muzaffarpur)
4. Nidaan (Patna)
5. Harijan Adiwasi Shikshan Prashikshan Kalyan Sansthan (HASPKS, Purnea)

The above sites for Quality TI were subsequently allocated 4-5 neighbouring TIs to mentor and support at a later stage in the intervention.

Building Organizational Capacities

The responsibility of overseeing the administrative and programmatic requirements of all TIs in the state rests with the TI division at SACS. There are two staff members placed in this division– Joint Director and Assistant Director. While in many other states this team is supported in capacity building by STRC and technical assistance is offered by state Technical Support Units, BSACS had no such support available. The BSACS officials with multiple responsibilities at the state level had limited time for field visits, mentoring or to plan and conduct trainings routinely. As a result most TI staff members were not trained in the past 1-2 years and there existed a limited system for supervision of onsite processes or regular feedback on monthly reports. Other concerns at the TI level included incomplete recruitment, a lack of clarity on specific responsibilities of each cadre, overlapping and duplication of reporting responsibilities, inadequate orientation of new recruits, high turnover, and inadequate understanding of the focus of outreach activities. Most teams had not been trained on the NACO prescribed modules.

As many of the above issues were beyond the purview of the S2N initiative, the strategy adopted by Alliance in Bihar was to work intensively with TIs for enhancing programme quality. At the sites identified for Quality TIs, the focus was on onsite mentoring, structured capacity building for all cadres, exposure visits, and streamlining processes for reporting and review. The capacities of other TIs were built through centralised trainings. The non - TI NGOs were trained centrally on understanding TI and a few were mentored through site visits.



Strengthening Sites for Quality TI

"I was never able to speak with confidence about my work with the PE. Often because of various factors PEs would leave their jobs and those who continued I sensed were a little bored. There was nothing new I could offer them and the work was routine. I had many doubts on the reporting formats, which I was unable to clarify. Going to the Alliance India trainings, has helped me understand my role better. The PO helped us take our learnings from the training and apply them at work. I have walked through each format and tool in the past 6 months and I am often called upon to clear doubts of the others in the team! I have new information and understanding which I can pass on to my peers. When visitors like you come to the TI, I'm often asked to speak to them. I have no fear now, I understand my community well and am aware of the gaps in the project and what has been most interesting in the past year is that we have together tried to find solutions to address these gaps"

- ORW from a site for Quality TI

Voices from the field, such as the experience of the ORW given above, capture how the steps set in motion a process that was found to be not only significant from the point of view of leading to programme outcomes, but also note-worthy in terms of the impact it had on morale and motivation of the work force. Alliance India, during the assessment phase, identified critical lacunae such as those described above, through interactions with TIs and observed that there was a need for rapid enhancement of capacities of the staff and the parent organization's capacities in mentoring and monitoring.

Thus, a large focus of S2N support in the state was on building capacities of sites for Quality TI. Some of the efforts towards this end included streamlining recruitment, delineation of roles and responsibilities, training, exposure visits, strengthening data and reporting, and institutionalising evidence based reviews.

"When I started work with this team, it was evident that they were enthusiastic and committed to the programme, but there were gaps in their understanding of what a TI needs to achieve as well as their own roles within it. We realised that while working on building knowledge and skills through structured trainings was important, it was equally important to work with these teams on field to help them understand their roles, work with them in streamlining systems for reporting, help them look at their own data and use it for planning etc. Since supervisory visits were unfamiliar to these TIs, our support was initially viewed with some suspicion and then gradually welcomed!"

–Alliance Official

Recruitment

NACO guidelines prescribe one Project Manager (PM), one Counsellor, one Accountant, one Monitoring & Evaluation (M&E) Officer (wherever required according to the guideline), one Outreach Worker (ORW) per 200-250 HRGs and one Peer Educator (PE) per 60 HRGs. The initial assessments revealed that the TIs were not staffed optimally and the number of PEs and ORWs were also lower than the recommended numbers.

One of the reasons for recruitment gaps was delay in release of funds for the project and the delays in re-contracting TIs post year- end evaluation. While trying to urge SACS to release funds on time, Alliance worked closely with the Project Directors (PD) of the TIs to impress upon them the necessity of adequate staffing to run a Quality TI. Where required the NGOs were also guided on recruitment processes and selection of suitable candidates. As on 1st May 2014 all TI are staffed optimally. Another significant achievement has been the two month extension of contracts for all TIs for the new financial year (2014-15). This initiative from BSACS will ensure that there are no gaps in service delivery that were earlier observed during the re-contracting process.

Delineation of Roles and Responsibilities

With recruitments streamlined, on-site mentoring commenced with the Alliance team helping each cadre understand its overall responsibilities as outlined in the NACO training manuals for different cadres. The flow for reporting and responsibilities on field were delineated for each cadre and through regular site visits the POs monitored the progress.

"I visited the sites under my charge at a time convenient to me and met the women who were available there. On occasion the ORW accompanied me. Slowly, as we understood the responsibilities of everyone in the team, I realised that there is so much more we could be doing at the hotspots. With the help of the ORW I was able to set up condom depots, interact with women who were earlier not willing to listen to me, analyse based on condom demand and the number of clients she entertains whether the sex worker was actually using condoms in each encounter and if not, thinking about ways of convincing her. I didn't know the importance of regular medical check-ups and that as PE I was expected to convince women of its importance! I've started discussing this on field too. I am confident that I am a better PE now than I was last year."

- A PE from a site for Quality TI

Training

NACO has developed comprehensive training modules for all TI staff and these are currently used by STRCs across the country for TI training. BSACS too has used these modules to train TI. However as there is no dedicated agency or personnel working on trainings, the gap between trainings was long and often staff remained untrained for over a year after joining the project. Also, the modules used were in English making it difficult for some facilitators and participants to engage actively with the learning process.

Alliance has extensive experience in training and capacity building of TIs in AP. One of its learnings from the AP experience was that tailoring trainings to the local context of the participants is critical. Language was the first consideration in Bihar and while NACO packages were developed in English and translated for

local use, BSACS and its TIs did not have the Hindi translation of the packages. Alliance was able to obtain Hindi translations of the package from other states and use these in the trainings under S2N.
To ensure that the trainings were attended by all staff and there was ownership of the training process, Alliance and BSACS ensured that the latter was actively engaged in the planning and implementation of the training. BSACS engagement further helped in prioritisation of training topics.

Exposure visit to Quality TI site- Muzaffarpur

While all partners under S2N had available a skilled and competent team to facilitate trainings, to ensure that a resource pool of trainers is available with the state, Alliance worked towards identifying trainers from within the state. In addition to the S2N team, the facilitators were drawn from other agencies working on HIV and related themes.

Project Managers (PM) received the maximum number of trainings, followed by Outreach Workers (ORW). The doctors and counsellors were trained on sexually transmitted infections, syndromic case management, and reporting formats. The training of counsellors and doctors was facilitated by Family Health International 360 (FHI 360).

Most training took place centrally and PE trainings followed a decentralised and cascade model. One ORW and PM from each site for Quality TI were trained to facilitate PE trainings and Alliance supported these trainings on site. The factors guiding the decision for decentralised trainings were the large number of PEs and the high turnover rates among them. A decentralised model served to build capacities of the staff of TI to orient and train new PEs as and when they join the project. This was an important contribution of S2N in the state, as in the absence of an STRC, trainings in the state were not streamlined. Through

the decentralised training of PEs not only is it possible to have regular TI level training of PEs, but also to use PMs and ORWs as a resource pool of trainers that can be used for centralised trainings or trainings in neighbouring districts.

Training of Trainers for Decentralised PE trainings

To support the PE in communication at the field level and to create a group of trained individuals in the community, a pool of Community Educators (CE) were identified at each site for Quality TI. This group was oriented on the basics of the TI programme and inter-personal communication. In the sites for Quality TI, 2 CEs who were trained under S2N, have been recruited as PE and 1 has been recruited as an ORW.

At the close of S2N, i.e. June 2014, the status of trainings is as given below

Table 1: Trainings for 5 sites for Quality TI

	Title of the training	Participants
1.	MIS Systems and Reporting ToT	5 PMs+5 M&E Assistants
2.	STI and Syndromic Case Management	5 TI Counsellors and 6 Doctors
3.	Programme Management	5 PMs
4.	Orientation	5 PMs and 22 ORWs
5.	Peer Education- Training of Trainers	5 ORWs + 05 PMs
6.	Peer Education	78 PEs
7.	Counselling	TI Counsellors
8.	Finance Management	5 Accountants

9.	Community Educators Training (Phase 1)	10 CEs
10.	Community Educators Training (Phase 2)	10 CEs
11.	Refresher Training PM	5 PMs
12.	Refresher Training ORW	22 ORWs
13.	Refresher Training PE	60 PEs
14.	TOT on Chalo Milkar Seekhen, a package for PE trainings	5PMs and 5 ORWs
15.	Advocacy skill building workshop	5PMs and 5ORWs

Exposure Visits

"We are a TI led by a Community Based Organisation (CBO) led TI and so were they (in AP). And yet the difference between us was so visible. Both had commitment but the difference was in the range and quality of work taken up by them and the confidence with which they presented it. While working on the core focus areas of TI we have also been thinking about our CBO and its future. We have people now to focus on income generation activities which support the CBO and out- of- work sex workers. This money helps us to respond to the many needs that our women have that cannot be met by the TI budget. The possibilities are so many and we have started working on them. I want to show that CBOs are best suited to run quality TI as we are the people the programme caters to."

- PM from CBO site for Quality TI

Bihar has no TIs serving as learning sites and opportunities for TI staff to visit each other were also limited. To prepare Quality TI sites to function as sites for learning it was important to help them visualise the qualities required of them. Alliance in AP with the support of CARE has developed learning sites amongst its TIs and exposure visits from Bihar to AP was seen as one means of building a vision and strengthening capacities among TI staff in Bihar. PM, ORWs, PEs and CEs were identified from each site for Quality TI and were sent for exposure visits to the CBO- led TI intervention and learning sites at Guntakal and Karimnagar. The visits to the CBO led site were geared towards helping the Bihar team get an overview of

the programme, facilitate interactions with field staff to understand on-going activities and to understand the procedures and systems followed in the field, which the Bihar team could consider for replication. In addition, the team from Bihar also had interactions with officials from APSACS, Alliance, AP- TSU, CARE and Pehchan projects.

The teams were keen to absorb and understand the on-ground functions of the CBO TI and were able to get a feel of community mobilization, crisis response and positive health and prevention components, which they were not exposed to within Bihar. These visits took place parallel to the on-site mentoring and training processes, and helped the TI teams to view the S2N initiative as a process which could help them reach the level of maturity of interventions they were witnessing in AP.

Key learnings

1 Trainings must be planned and implemented through the State AIDS Control Society- this encourages ownership among the TI.
2 It is important to ensure that local capacities are strengthened ; resource materials should be provided in the appropriate language, local stakeholders/partners should be engaged for training, and a resource pool from amongst the TI staff should be created.
3 Decentralised training for PEs allows for both building capacities of local facilitators and ensures a faster coverage of training as opposed to centralised PE trainings.
4 Exposure visits are a means to help TIs visualise what mature interventions look like. Visits help to demonstrate that certain practices, achievements and processes are possible and encourages reflection on different means to achieve them.

Building Systems for Monitoring and Review

While the sites for Quality TI were enthusiastic and open to learning, in the absence of regular training and minimal on-site support their understanding on data quality and processes for evidence based review was limited. Formats were partially maintained and most data was maintained in registers and files, making periodic compilation and analysis cumbersome and prone to errors. The understanding of CMIS indicators was also limited with concerns regarding both completeness and correctness of data. Tools for planning and analysis were not in use. These gaps were worked through by way of training and on-site support with a special focus on strengthening data quality, reporting, evidence based reviews and a mid-term assessment to understand progress of the support.

"I enjoyed field work - going to hotspots, meeting with the community, talking to them about health services and I thought we were all doing a good job. Earlier, all of us did everything together, field work, documentation, reporting etc. Now we can see how each of us has a distinct role to play and contribution to make to the project. It is not something that we had consciously thought about before, nor did anyone draw our attention towards it. It was only once the Alliance team started visiting us, that I realised that while we shared a good relationship with the community, we were not able to help them move towards better health. What should my focus be? How can I plan my work in a way that I am able to offer my best to the PE working with me? What exactly is my role as an outreach worker? These questions and the day-to-day support has made us more efficient in achieving the project's objectives"

- ORW from a site for Quality TI.

Strengthening Data and Reporting

Like most other aspects of support for sites for Quality TI, capacities on data and reporting were strengthened through structured centralised training as well as hands-on support at the TI level. Alliance worked closely with each site for quality TI to assess the bottle necks in review and reporting. While a few NACO prescribed tools were in use, there were errors in following the guidelines and in recording the data.

Some of these gaps were a result of inadequate understanding of the purpose of the format/tools and others because most tools were in English and the staff, especially PEs, were not able to understand them adequately.

Alliance ensured that Hindi translations for all formats were made available to the TI and the staff was supported in understanding these and allocating responsibility for completion of each based on the NACO guidelines (Table 2). In addition to the onsite support, structured centralised trainings were also provided to PMs and M&E Officers, and sessions on formats and tools applicable were included in the trainings across all cadres.

Another critical bottleneck in using evidence for programme planning was that most information was documented by hand in registers and files. None of the formats and tools were computerised. For instance the HRG master register or Form E was maintained in a register and compilation and analysis of the data recorded in it was manually undertaken and hence cumbersome and prone to error.

Correcting reporting errors

Excel sheets for auto-generation of certain data in formats were used by Alliance in AP and this reduced the reporting burden and made data compilation and analysis simpler. The M&E Officers in the Bihar Quality TI sites were also trained on its use. This made compilation and reporting easier and reduced errors in data entry. For instance, in one such auto-generated format, the data for PE Weekly Planning and Activity Sheet or Form B is to be entered and the PE wise individual HRG Compiled Monthly Sheet or Form C is generated automatically. Tracking sheets for HIV and Syphilis and for RMC are generated which are then provided to ORWs to facilitate field follow up through the PEs. The 23 digit UID were also not allocated at the TI level and this too was streamlined through S2N support.

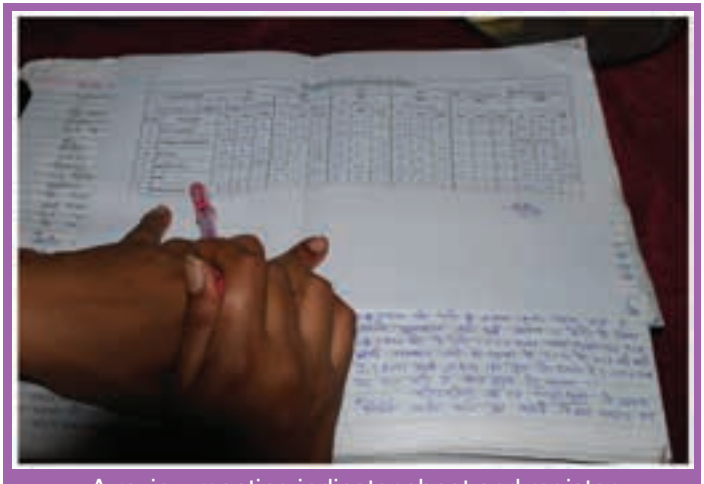
Table 2: Cadre wise formats		
Name of Staff	**Type of Forms used**	**Frequency of Usage**
Peer Educator	Peer Educator Weekly Planning and Activity Sheet (FORM B) for FSW and MSM+FORM B_1 for IDUs	Daily
Outreach Worker	HRG Registration format (FORM A)	As and when a new HRG is identified at the site level
	PE- wise individual HRG compiled Monthly Sheet (FORM C) + Monthly summary sheet (FORM C_1)	Weekly
	Outreach Weekly Report (FORM D)	Weekly
MIS Officer/Accountant	HRG Master Register (FORM E)	Weekly
Doctor	Network Clinic Register (FORM F)	Daily
ANM/Counsellor	Clinic Daily Summary Sheet (FORM FF)	Daily
	Medicine Stock Register (FORM G)	2-3 times per week
	Referral Register/Slips (FORM H)	Daily
	Counselling Register (FORM I)	Daily
	Drop-in Centre Register (FORM M)	Daily
	Daily Drug Register	Daily
Programme Manager	Advocacy Register (FORM J)	Once/Twice a month
	Crisis Management Register (FORM K)	Once/Twice a month
	Training Register (FORM L)	Usually once in a month
	Stock Register (FORM N)	Weekly
	Movement Register (FORM O)	Daily
	Community Mobilisation Activity Register (FORM P)	Once in 2-3 months

"I sat with ORWs each week, and usually used this meeting for reporting. We looked at the number of meetings held at hotspots, the number or condoms distributed and a few other indicators. We reported based on our understanding of the formats and though we were confused there was really no one who could clarify these for us. After the trainings, and after working with Alliance we started reviewing the programme closely. It was then that we realised that we were not filling certain forms or indicators correctly - we reported all women who visited the STI clinic as 'treated' and we realised that we were not even using a few prescribed formats! Earlier there was a weekly meeting every Saturday but that changed and a dual cycle of meetings was initiated. Every 7th, 14th, 21st and 28th of the month there is a meeting between the ORW and PE. Then, every 8th, 15th, 22nd and 29th of the month there is a meeting of the ORW with the PM to understand the overall situation. Our meetings are more focussed now; we review critical indicators and also look at data quality aspects."

A PM from a site for Quality TI

Evidence Based Reviews

Review meetings at TIs were held largely to compile reports on a weekly basis. Alliance worked closely with the NGO management to impress upon them the need for comprehensive review of the TI project. Basic indicators for review of each level of staff were outlined. Alliance tried to ensure that during review meetings, information from different tools and formats were looked at to understand areas of focus for each staff member. For instance, while review meetings of ORWs with PEs focussed only on recording outreach contact, clinic visits and condom distribution, ORWs now have shifted focus to understand the gap in the number of sex workers accessing these



A review meeting indicator sheet and register

services. This was supported through the use of tools like spot analysis, contact mapping etc. and their impact is visible on the service uptake (details in a subsequent section). The focus of the review meetings between PMs and ORWs is on overall ORW-wise performance and concerns pertaining to stakeholder engagement, community events, advocacy etc.

Mid-term Assessment

To further strengthen the processes of building organisational capacities, mid-term participatory assessment of the programme was conducted. The S2N mid-term assessment was designed to be similar to NACO's own assessment processes. The three main components of TI as it appears in NACO's assessment framework were retained, viz., Programme Delivery, Organizational Capacity and Finance. Minor changes were done for the Programme Delivery component, to customize it so as to suit the requirements of the S2N initiative. While Programme Delivery is the crux of the TI programme and S2N primarily focused on the same, the assessment scores were stretched from being limited to only 3 indicators (as it appears in NACO's tool) to a 5 point scale. The S2N 'trainings being conducted' and the 'readiness of the Q TI for Objective 2' are the two indicators that were added to the existing tool.

The status of sites for Quality TI during the mid-term assessment is provided below. The scores obtained for each indicator have been plotted on a scale of 1-5. Grade A was assigned to scores 5 and 4, B to scores 3 and 2 and C for score 1.

Outreach

Table 3: Mid-term Assessment, Outreach

Indicators	TI Names				
	Patna	Muzaffarpur	Begusarai	Purnea	Madhubani
Micro plan	B	B	B	B	B
Regular contacts	A	A	A	B	A
Prioritized outreach	B	A	B	A	B

Hotspot level meeting	B	A	B	A	B
Review meeting	B	A	C	A	B
Field visit by ORW	B	A	B	A	B
Outreach tools	B	A	B	A	B
Communication	B	A	B	B	B
Outreach documentation	A	B	B	A	B

Clinic

Table 4: Mid-term Assessment, Clinic					
Indicators	**TI Names**				
	Patna	**Muzaffarpur**	**Begusarai**	**Purnea**	**Madhubani**
Setting up STI clinic	A	A	B	C	C
Quality STI services	B	B	B	B	B
Quality counselling	B	A	A	B	B
Clinic visits	B	B	B	B	B
ICTC tests	C	A	B	A	B
Clinic documentation	B	B	A	A	B

Commodities, Linkages and Reporting

Table 5: Mid-term Assessment, Commodities, Linkages and Reporting					
Indicators	**TI Names**				
	Patna	**Muzaffarpur**	**Begusarai**	**Purnea**	**Madhubani**
Condom Gap Analysis	A	A	B	A	B
Distribution of condoms	C	A	C	A	B
Linking Positives with ART	C	A	C	C	C
Referring TB cases to DOTS	C	B	C	C	C
CMIS report	A	B	A	A	B

Key learnings

1 Clarity on responsibilities of each cadre is critical and only if each one is playing his/her part effectively can change be visible. It is vital to help the staff to see the connection between their responsibilities and the quality of intervention and achievement of objectives.

2 While trainings are one of the first steps to build staff capacities, in order to sustain impact regular on-site support and mentoring is critical.

3 Correct documentation at field level and review of the data ensures evidence- based planning.

Building capacities of Linked TIs and Non- TI NGOs

Assessment of Linked TI

The plan at the initiation of S2N was to build capacities of the non-learning site TIs (Linked TI) through the learning site TI and to facilitate further mentoring for them. As the strategy changed from building learning sites to building sites for Quality TI, the Linked TI were provided on-site support through mentoring visits in some of which the staff for the Quality TI were engaged.

The initial baseline assessment scores for all Linked TI are provided below. All TIs scored within the ranges of 34-45 or below 33 (out of a maximum score of 100). The findings from the assessment were used by Alliance as areas of focus for mentoring visits to Linked TI.

Table 6: Assessment Scores of Linked TI

S. No	District	TI NGO	Assessment Score
1	Rohtas + Aurangabad	Suraje	29

2	Bhojpur	Gyan Bharti Shiksha & Prashikshan Sansthan	23
3	Buxar	Jayprabha Gram Vikas Mandal	36
4	Kaimur	Environmental Consultancy Vikas Centre (ECOVIC)	30
5	Katihar	Welfare India	30
6	Khagaria	Gramin Bal Evam Manav Vikas Samiti	37
7	Kishanganj	Koshi Anchal Samagra Vikas Evam Kalyan Parishad	24
8	Lakhisarai + Sheikhpura	Paridhi Bharti	35
9	Munger	Bal Mahila Kalyan	29
10	Nalanda	Bhartiya Jan Utthan Parishad	29
11	Nawada	Srishti International	28
12	Samastipur	Adarsh Mahila Shilp Kala Kendra	31
13	Saran	Dr. B.R. Ambedkar Harijan Kalyan Parishad	27
14	Siwan	Narayani Seva Sansthan	23
15	Darbhanga	Seva Sankalp Evam Vikas Samiti	30
16	Vaishali	Swargiya Kanhai Shukla Samajik Sewa Sansthan	34

Trainings of Linked TI

Training for all staff was conducted centrally and a few batches were common for both sites for Quality TI and Linked TI, for instance trainings of Accounts Assistants and MIS Officers included both Quality TI and Linked TI staff. The training for Programme Managers of all Linked TI was conducted at Muzaffarpur to

Chalo Milkar Seekhen: This is a training package for Peer Educators developed under the S2N initiative in Bihar. It is based on select themes of the NACO package for training Peer Educators. The package is developed in a modular format where short sessions of 2 hours each are available for eight topics. The visual-based package is intended for low-literate audiences and is designed in a manner that provides for continuity from classroom to field application of learning.

The final package consists of a facilitator's manual, visual aids for training such as posters and situation cards, as well as an outreach tool for Peer Educators for field based discussions.

facilitate visits to Quality TI sites in the same town. The visit to the Muzaffarpur CBO was seen as especially inspiring by the PMs as it provided a much needed example of what practices should be in place at Quality TI.

The training of ORWs was conducted centrally and refreshers were organised at the TI level and supported by the Alliance team. Through the process of training of PEs at sites for Quality TI, the TI staff and S2N team recognised the need for a) a capsule approach for on-site need- based refreshers and b) a comprehensive outreach communication tool for PEs. The Communication Hub was contracted to develop a modular training package for PEs. This package is called – *Chalo Milkar Seekhen* (see box) and the final round of cascade trainings for both sites for Quality TIs and Linked TIs follows this module.

The clinical staff (doctors and counsellors) and MIS Officer were trained by FHI 360.

Table 7: Trainings for Linked TI

S. No.	Title of the training	No. of Participants
1.	Counselling	16 (Counsellors)
2.	Finance Management	16 (Accountants)
3.	Community Educators Training (Phase 1)	32 (CE)
4.	Community Educators Training (Phase 2)	32 (CE)
5.	Programme Management	15 (PMs)
6.	Capacity building of ORWs	42(ORWs)
7.	Syndromic Case Management and Clinic Systems and Protocols	18 (Doctors)
8.	Clinical Services	20 (Counsellors & M & E)
9.	ToT on PE Module	32 (PM and ORWs)
10.	Advocacy Skill Building Workshop	32 (PM and ORWs)

On-site Mentoring

When the S2N team started working with Linked TIs, we wondered about what knd of response we would get from the Linked TI. We found that most Linked TI were eager to receive support! By the time we started visiting them they had already heard about our support to sites for Quality TIs and were looking forward to our visits. Through informal interaction with Quality TIs, these Linked TI had already adopted a few good practices. Notable amongst these were mapping, display of IEC material in the DIC, filing systems and processes etc.

PHFI Official

As discussed above, each site for Quality TI was linked with 4-5 neighbouring TIs. The prime consideration for this distribution was geographic proximity. BSACS communicated to the linked TIs the plan for on-site support and trainings under S2N. As by this time the efforts of S2N were already yielding results at sites for Quality TI, the linked TIs welcomed the S2N support.

***F**eedback from PMs on exposure visit to site for Quality TI*

1. *Individual case sheets for HRGs is a practice we want to replicate*
2. *All staff had a very clear idea about their role and they were able to tell us about it clearly!*
3. *Computerization of all data is very helpful. We don't do this in our organisation, I look forward to being able to streamline this after training.*
4. *The detailed micro plan is something we will also try to incorporate in our TI*

After an initial visit to all Linked TI, Alliance developed a field visit and mentoring plan. The mentoring visits focussed primarily on strengthening systems for monitoring and review. Influenced by the positive experiences of the site for Quality TI, the Linked TI were welcoming of S2N support and a few were quick in adopting the review and monitoring systems recommended. The areas of focus for the mentoring visits are provided in the box below.

On-site Support for Linked TI was focussed on

1. Prioritising outreach based on risks and vulnerabilities
2. Capacity building of ORWs and PMs on NACO prescribed outreach planning and mapping tools as well as the Clinic Tracking Tool
3. Processes for review and monitoring–conducting effective programme reviews
4. Initiating processes for 23 digit unique identification number for HRGs
5. Delineation of roles and responsibilities of cadres
6. Record keeping

Non-TI NGOs

"Our organisation was registered in 2002. We have worked in the district on issues of health, education, skills training and have also been associated with projects related to Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA). We once were a part of an awareness programme in schools about HIV/AIDS and this inspired us to work on HIV awareness. We looked at existing modules on HIV awareness for schools and worked with a few schools in imparting information to young people. None of this was funded by any agency, it was done because we wanted to do some work on HIV. Based on some of our applications to BSACS, we were also empaneled with them. This training organised by Alliance and BVHA has been an eye opener for me in many ways. I had not worked with sex worker groups or MSM groups and learning about TI was very informative. Despite having worked in schools on HIV, I had not interacted with any positive person. In the training I met a PLHIV for the first time and he was very comfortable answering our questions and talking about his life! This was truly motivating. Another major impact this training has had on our organisation has been the building of systems – especially in managing finances and human resources. We started this organisation because we wanted to do something for society, we didn't pay close attention to systems and requirements but after the training I have realised how important these are for accountability and growth! We are keen on working with BSACS and look forward to future opportunities."

A PD from a non-TI NGO

A common practice across states is to identify competent organisations who can implement TI, to initiate new TI with newly identified populations or to run a TI for an existing population in the event that existing NGOs need to be discontinued based on annual evaluation findings. Like most states, BSACS too maintains a list of such NGOs. S2N was assigned to a) expand the database by including new NGOs b) Strengthen their capacity in the HIV Programme and c) Support short-listing NGOs for Pre-grant assessment by BSACS.

Alliance was supported in the above activities by Bihar Voluntary Health Association (BVHA). As a first step towards the above activities, Alliance reviewed the list of NGOs empaneled with BSACS and identified those which had not received any TI related capacity building. Further, the profile of NGOs in the BVHA network was also reviewed. As the BVHA network NGOs had longstanding experience of working on health- related issues in the state, Alliance recommended that they also be considered for empanelment and capacity building efforts.

Further, Alliance worked with BVHA to develop the design for trainings of such NGOs and identified resource persons from organisations associated with NACP. Representatives from 31 NGOs were trained in 2 batches on the topics given below. As a part of the trainings the participants also developed action plans for developing the capacity of their organisations. Critical elements of these plans were a) initiating in-house capacity building on the learnings from the centralised trainings, and b) the streamlining of systems and procedures post trainings. Members of the BVHA team also visited 22 NGOs with the aim to understand the progress made and to offer on-site support for any concerns faced by them.

Joint Assessment/Appraisal Teams were constituted by BSACS to assess capacities of potential NGO partners and 16 NGOs trained and mentored under S2N were visited by these teams.

Topics for training for Non-TI NGOs

1 Evolution of NACP
2 Basics of HIV and AIDS
3 Syndromic Case Management
4 Counselling Skills
5 HIV/AIDS Scenario- Bihar
6 Vulnerability factors- High Risk Groups and Bridge Population
7 Prevention, Care & Support Services
8 Introduction to Targeted Interventions (Type, HRG Mapping, Components, Staff roles and responsibilities)
9 Role of Governing Body
10 Empanelment with BSACS - Application Process
11 Appraisal Visit – Procedures and Checklists
12 Understanding Vulnerable Communities
13 Integrating HIV in existing programmes

Key learnings

1 Tapping into the network of other organisations working on health in the state can be a fruitful means for identifying and engaging with more organisations that can be part of the TI programme.
2 While the capacities of these organisations are built on understanding the TI programme, it is also critical to help them streamline organisational systems and procedures to standards which are at par with those mandated by NACO/SACS.

Strengthening Services in Sites for Quality TI

Outreach and clinical services were studied as a part of the baseline assessment undertaken at the beginning of the programme. Major gaps observed through these assessments were: absence of line listing of the population; no prioritisation of PE outreach; absence of project- run clinics in some TIs; inadequate clinical instruments and equipment; STI drug stock out or expiry; condom stock out; limited and inadequate assessment of condom demand and supply; weak reporting and M&E systems. Alliance worked towards helping the TI level staff to understand the status of their intervention through the use of NACO prescribed tools. This helped each TI get a better understanding of their limitations and Alliance supported them in rolling out strategies to address these. While promoting a critical understanding of the programme indicators and identifying solutions was facilitated on one hand, on the other Alliance worked towards ensuring adequate stocks and commodities at the TI level, which would be required to cater to the enhanced demand for services.

Discussing S2N progress!

Outreach and DIC

The S2N capacity strengthening and technical assistance in the state has the ultimate goal of impacting the services provided by the TIs and their uptake by HRG communities. While the duration of the

intervention has been short (operational between May 2013 to June 2014), Alliance supported the sites for Quality TI in critically reviewing the reach and quality of services provided. The use of NACO prescribed tools has been especially beneficial in these processes and the experiences of using a few of these tools are described below and in the subsequent section in strengthening clinical services.

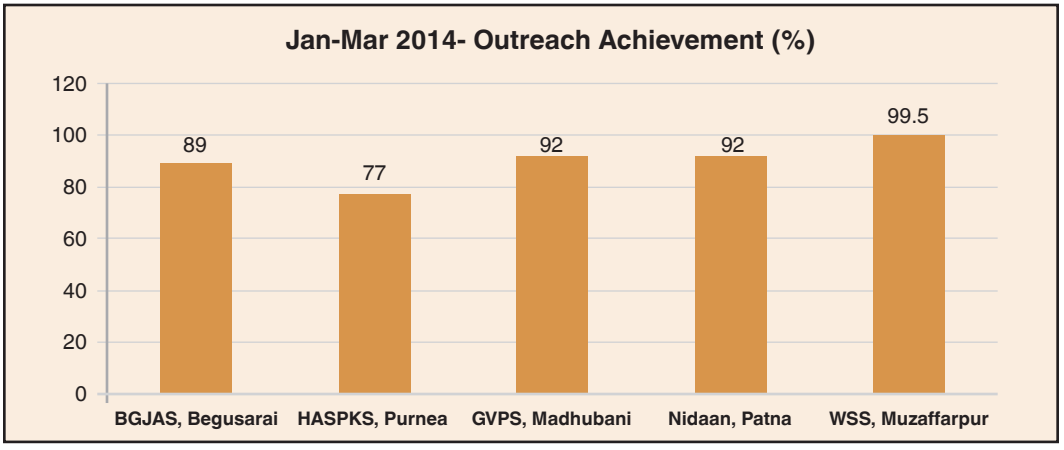
"I have 4 PEs working under me and they are responsible for 50-60 sex workers each. We have seen new sex workers in sites before but were too burdened by our own responsibilities to pay any special attention to them. Everyone knew at least 4-5 sex workers who were new to each hotspot, and when we pooled these numbers together we understood how many women we were failing to reach! Also, prioritising based on parameters such as client volume and age helped us streamline work with the existing groups and cater to new sex workers as well!
- ORW from a site for Quality TI

Hotspot analysis is a process recommended by NACO through which the situation for each hotspot is reviewed through multiple parameters such as client volume, typology and age of sex workers as well as the frequency and time of operation. One of the observations of the exercise was that while staff were familiar with the different locations and the kinds of sex work taking place in each, minimal efforts were geared towards understanding the risks and vulnerabilities of each population and tailoring outreach to suit this. The classification based on client load (high/ medium /low) and the age of the sex worker were aspects which the team focussed on for prioritisation of outreach.

Contact mapping was used to map a PE's contact with sex workers in each spot and plan for outreach based on these contacts. The exercise was done with PEs and ORWs on a map of the town and the visual mapping was then tabulated for each spot. Critical questions that guided the discussions were – Based on TI estimates/mapping, which are the spots where contacts are limited? Which spots are not covered adequately by outreach? Who is the project not reaching? By understanding the geographic and social networks, strategies to increase contacts in each of the spots were outlined and plans for action developed. The ORWs and PEs were focussed more on ensuring that sex workers registered in the project are reached but had a limited understanding of the need to reach new sex workers. The need to work with new sex workers in a hotspot was a major learning for the team.

A common observation on PE outreach was that it was unplanned and largely based on convenience as opposed to a critical understanding of the need for communication with specific HRGs. ***Peer Maps*** were used to understand and analyse outreach done by PEs. The area that the PE was working in was mapped and each sex worker she was responsible for was indicated on the map along with an indication of her client volume. The ORWs and PEs were encouraged to look at how the PE outreach was planned. Through this tool ORWs were helped to review PE activities based on questions such as- Were all sex workers met at least once? Was communication and outreach based on the volume of clients of a particular sex worker and other risks and vulnerabilities faced by her? How did the PE understand the sex worker's condom requirements? Do all sex workers know about condom depots and outlets?. Through the use of these tools and aided by the mentoring processes, outreach in 2 sites for Quality TI was recorded between 75-90% and in 3 sites over 90% (Jan-Mar 2014).

Maps Displayed at a DIC



"Our communities are not always welcoming us as PEs. For some time I have been known as the 'AIDS walli' by other women. Over the past few months, as we started to talk to auto drivers, paan shops, brothel madams etc. to build support for our work, I also saw a change in the behaviour of the women around me. Suddenly, I'm not just 'AIDS walli' for them! I think it is because I started looking at other issues and needs that affect us. I still talk about STI, HIV/AIDS and Condoms, but I am now more conscious about what I should be talking about to each woman or stakeholder. Earlier, It was usually just-'Come to the clinic' and 'Do you need condoms'!

- A PE from A site for Quality TI

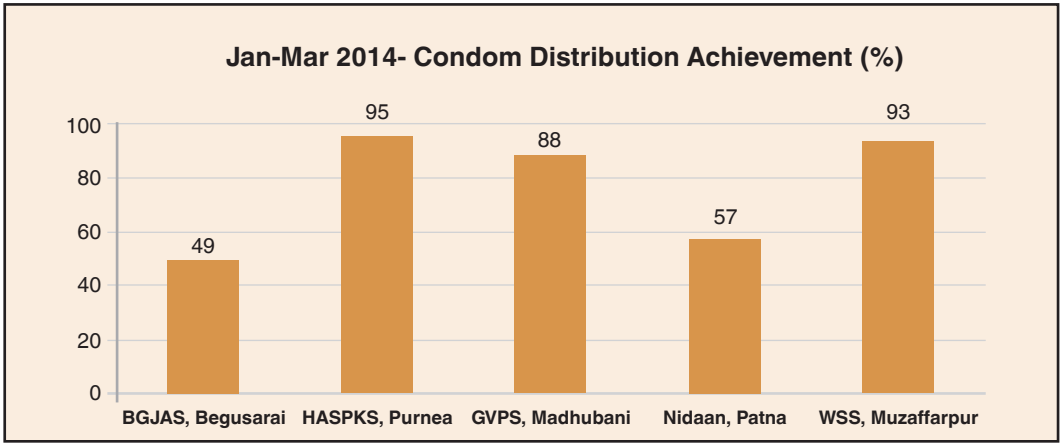
"PEs were distributing condoms to sex workers, but we didn't really ask a sex worker how many clients she had nor did we explore ways of ensuring that condoms were available from other sources. We realised the problem with this approach, when we looked at it through the spot analysis and condom access maps. In the past year we have established a minimum of one depot at each spot and have approximately 15 outlets in town!"-

- A PM from a site for Quality TI

While PEs routinely collected condoms from the TI and distributed these to sex workers they met with, there was negligible focus on understanding condom requirements or the accessibility of condoms through sources other than the PE. ***Condom Accessibility and Availability Mapping*** exercise supported an analysis of this. Critical questions that guided the reflection were- Are there condom depots/ outlets in the sites where sex workers solicit or have sex? Are these operational during the hours that sex workers operate and if so are these accessible to the sex workers (issues of fear, stigma and comfort)? This exercise was especially influential in reiterating the need for sex workers to have access to condoms at the point for solicitation and sex and it has led to identifying depot holders, outlets and options for communities to access condoms available under social marketing.

At the initiation of S2N almost all sites for Quality TI were facing a shortage in condom supply and there were stock-outs at 3 sites for Quality TI. Alliance India worked closely with BSACS to streamline supply and

also supported TIs to coordinate with government health facilities for regular supply of condoms. Between Jan-Mar 2014, 3 sites for Quality TI have achieved between 85-95% of the targets for distribution and 2 TI are between 45-60% of the same.



The use of such participatory tools for situational assessment and planning was new for most TIs. To ensure that they are familiarised with the processes of using each tool, the Alliance team supported them in using the tools at least once at each TI. The periodicity for each was explained and for some tools repeat cycles were practiced.

Tools for understanding outreach and clinical services	
1. Spot analysis 2. Contact mapping 3. Geographic and social networks 4. Sex work typology wise outreach planning 5. Site load mapping 6. Seasonal calendar	7. Force field analysis 8. Preference ranking 9. Peer map for condom distribution 10. Condom accessibility and availability mapping 11. Peer education card 12. Peer calendar 13. Opportunity gaps analysis

Activating Drop in Centres (DIC) – DICs are envisioned as safe spaces for sex workers. These are ideally located in spaces easily accessible to sex workers and they are most often adjacent to or within the same premises as the project office and static clinic. The DICs at the sites for Quality TI followed a similar pattern. One critical observation of the S2N team was the absence of activities for community participation in these centres. While sex workers who visited the clinic and the PEs made use of the DIC, the DIC itself was not seen as an attraction by the community. The onsite support of Alliance and the learnings of the exposure visit have helped TIs re-imagine and re-cast the DICs run by them. For instance, in Begusarai discussions with PEs and sex workers revealed that they would prefer to have their DIC slightly removed from the popular hotspots so that they can remain anonymous, whereas in Purnea the distance of the DIC from the hotspot was seen to be a barrier. While the shift has taken place in Begusarai, in Purnea the location of the DIC is still a challenge owing to budget limitations.

Across sites efforts were made to initiate DIC- based events, and providing facilities attractive to the community (TV, films, music). Monthly, and in some instances weekly, progress of activities and key indicators were also displayed in the DIC, along with IEC material, to make the DIC attractive.

> *"We take great pride in the fact that we are a CBO- run TI and we try to ensure maximum participation of our sisters (other sex workers) in the project. But seeing a CBO- led TI in AP got us all thinking. The DIC there was colourful, well equipped and felt like a great place to be in – I would love to keep going to a space like that! Our DIC despite being in the heart of our locality (the sex work population is brothel -based and the DIC is housed in the brothel area) could not attract so much activity like the ones in AP. We have since been after the Alliance team to help us set it up. Now we have regular activities at our DIC, the project progress is displayed and we notice that now women, especially the younger girls, drop in when they want to take a break. We call this place – Khushibadi – a garden of happiness!"*
>
> *A PE from a site for Quality TI*

STI Services

Case files at a clinic

Technical teams from Alliance and the FHI 360 team assessed the needs at each site using the Clinic Quality Monitoring Tool (CQMT - ref box). This tool supports the assessment of the quality based indicators such as space available, infrastructure, equipment, consumables, IEC, supervision and service delivery indicators. Most clinics in the 5 sites for Quality TI obtained C (26-50%;) and D grades (0-25%).The common gaps identified during the review were, limited access to clinical services for sex workers (issues such as distance, timing, day of operation), limited guidance available to doctors on Syndromic Case Management and lack of trained doctors, inadequate IEC material (SCM Charts, penis model) and clinical equipment (speculums were absent or inadequate in most clinics) record keeping was not optimum for example(no client wise files were available etc.) and waste disposal mechanisms were inadequate. The resultant programme gaps were low RMCs, low referrals to the ICTC and no focus on Syphilis testing. A stock out of the STI drug kits further added to the concerns.

Broad components of the Clinic Quality Monitoring Tool

1. Separate consultation area with auditory and visual privacy
2. Equipment
3. Consumables available (physical verification)
4. Training Status of the STI service provider
5. IEC (Job aids for providers and information for patients)
6. Infection control practices
7. Utilization of PPP by HRG
8. Supportive Supervision
9. Quality of STI/RTI Service delivery indicators, Referral and Documentation

Infrastructure, Drugs and Equipment

None of the Quality TI sites had received a supply of STI drug kits for over a year (August 2012-13). While initially Alliance attempted to build linkages with the district hospitals for STI drugs, the process involved multiple visits for each sex worker. In consultation with BSACS, Alliance procured and supplied the most commonly used drug kits to the 5 sites for Quality TI. Other equipment like proctoscopes, speculums, forceps, gloves and trays were also supplied by Alliance based on the number of clinics, and penis models were provided based on the number of PEs per TI. Referral directories were prepared by all counsellors and the information was displayed in the clinics.

STI Drug Kits

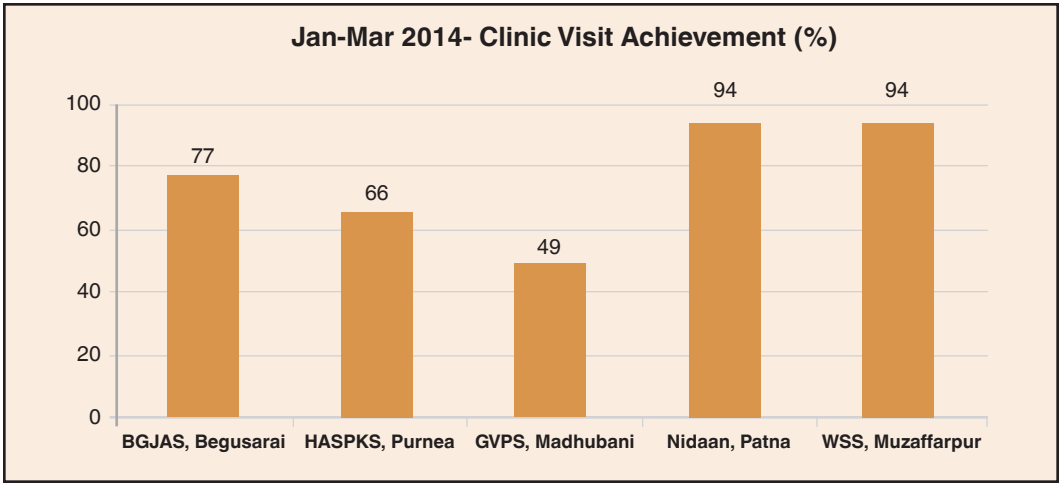
Making Services Accessible

"We realised that the distance from the clinic was a major concern for the sex workers. During our conversations with the doctor of the static clinic we realised that he too was not happy spending long hours at the clinic and having minimal patients. Dialogue with these two groups gave way to a simple strategy – now the doctor sits in fixed locations for 2 hours each day of the week, the community has been informed of this and they come in to meet him accordingly. The community is happy that the doctor is closer and the doctor is glad that he gets all his patients within a given time frame! The solution was not difficult to arrive at once the problem was identified."

PM from a site for Quality TI.

While the clinic itself was being refurbished, several tools were used to understand the reasons for gaps in clinic visits by HRGs. Preference Ranking was one such tool used during review meetings with PEs. Reasons for the low clinic attendance of sex workers were listed and factors such as distance from the clinic, time, information gap, etc. came to light. Site-specific strategies were then developed to address them. In many instances new PPs were identified and trained and in others existing ones were supported to cater more efficiently to sex workers. For instance PPs were identified and contracted in Muzaffarpur and Madhubani, and satellite clinics were established in Purnea. Muzaffarpur and Purnea have achieved over 90% of the target for clinic visits in the quarter –Jan-Mar 2014 and Begusarai is at 77% for the same period, Purnea 66% and Madhubani 49%.

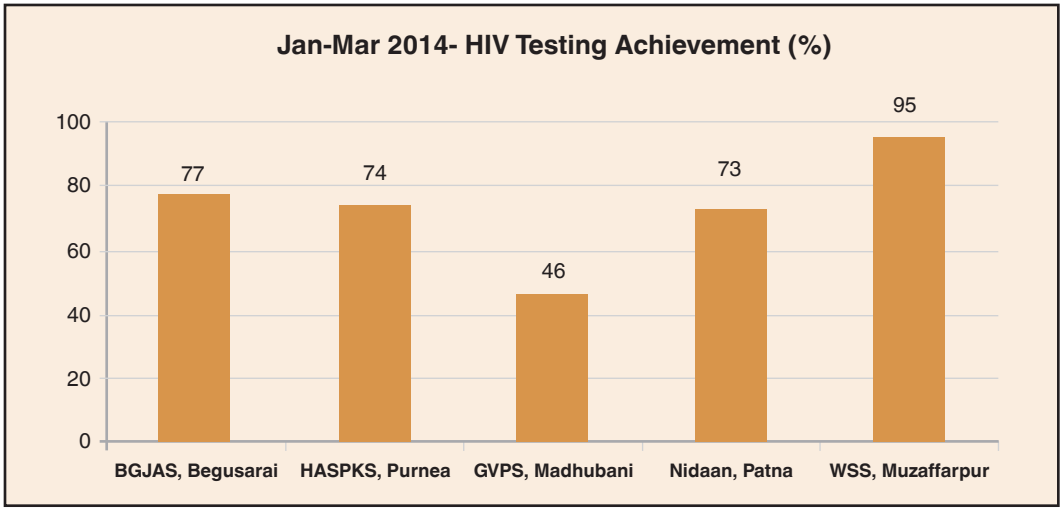
STI clinic at a TI



A greater focus was also given to streamlining the roles and responsibilities of the Counsellor. Counsellors were oriented on reporting formats and helped in understanding their role in facilitating referrals and linkages. An important activity streamlined through Counsellors was the cross verification of referral slips. Most sites were using referral slips in triplicate to refer HRGs. One slip was retained by the referral centre, one by the HRG and third one was kept at the project office. All cases referred –either through outreach or clinic - were given a referral slip and the same was noted in the referral register for tracking.

However there was almost no cross verification of the maturity of referrals. In case of STI clinics a degree of verification of referrals was made during the review of PEs where they were informed of the names of HRGs who visited STI clinics. In case of referrals to the ICTC, tracking of actual visit and testing was non-existent. To streamline the cross verification, the POs along with counsellors and the PM visited ICTC centres and helped the TI counsellor to establish linkages with the ICTC counsellors. Monitoring of referrals was further streamlined through the ***clinic tracking sheets.*** Between October 2013 and March 2014 Muzaffarpur has achieved the highest HIV testing at 95%, followed by Begusarai (66%), Purnea (74%), Patna (73%) and Madhubani (46%). Because of the efforts the counsellors now visit the ICTC once a week and collect the referral slips of HRGs who visited the ICTC centre during the week.

> *"We were very focused on encouraging sex workers to visit the clinic in case they experienced STI symptoms. The PE usually did not spend time on STI discussions with sex workers who 'looked healthy'. An important aspect we neglected was that STI could be asymptomatic and that regular health check-ups were essential for sex workers! Also in our focus on STI, HIV testing was often not discussed. Now I think we were not so comfortable in talking about HIV testing as we were worried whether the sex workers would resist. This has changed. We now are confident in our communication on both the issues".*
> *ORW from a site for Quality TI*



Syphilis Testing

Syphilis testing has been a challenge across most TIs in the state. The budget allocated was insufficient and sex workers too were hesitant to go for testing as they were referred to different laboratories for tests for which they had to pay a fee. Based on the request from BSACS, Alliance and FHI 360 rolled out Immunochromatographic Strip Test (ICST) Syphilis screening programme in two districts of Bihar (Purnea and Katihar) from 5th March to 7th March 2014. In Purnea and Katihar a Quality TI and Linked TI were engaged respectively.

A mix of personnel i.e. PM, Counsellor and MOs of 4 TIs were part of this exercise and ORWs and PEs of sites, where testing was scheduled, were provided detailed briefs. The Counsellors were oriented on counselling of HRGs on Syphilis screening, counselling of Syphilis reactive cases, counselling on partner testing and treatment, documentation of the ICST and also on using the tracking sheet for follow up after six months. The medical officers were oriented on Syphilis, its complications and treatment guidelines. ORWs and PEs were oriented on outreach messages and referrals.

A total of 180 HRGs were screened. Detailed sexual history, past history and medical history and treatment of previous STI were taken from all the ICST positive cases. All the positive cases were treated with STI Colour coded kit-4. Importance of partner testing was explained to ICST positive cases and they were referred to the nearest ICTC for RPR testing. All the ICST positives were asked to come for regular follow ups to ensure they adhere to treatment protocol and complete the course. None of the ICST positives had any signs and symptoms of Syphilis. All the ICST positives were asked to get RPR tests (both qualitative and quantitative) every 6 months. All the ICST negatives were counselled for safer sexual practices and consistent condom use and ICST testing every 6 months.

HIV Testing

Early detection of HIV through voluntary testing and linkages with treatment services for PLHIV HRGs serves to enhance the quality of life of HRGs and decreases the risk of transmission to clients and general populations. With this aim Alliance and Wama Shakti Vahini (a site for Quality TI) proposed to BSACS the organisation of HIV Testing campaigns for HRGs in different hotspots of Muzaffarpur. After obtaining a sanction from BSACS in March 2014 these camps took place in Muzaffarpur at heart of Charturbhujasthan (red light area) and at other hotspots through mobile ICTCs. The camps were planned keeping in mind timing convenient for HRGs. A total of 101 HRG (FSW and MSM) accessed voluntary testing through these camps.

Key learnings

1 It is important that TI teams are strengthened to undertake field level analysis and planning. Simple micro planning and review tools go a long way in helping TI to critically review their performance on field and address gaps.

2 Strengthening staff capacity in the absence of requisite infrastructure and commodities will have limited impact on the programme. Supply of commodities and a robust infrastructure are integral components in ensuring programme quality.

Coordination and Consultation with Stakeholders

Stakeholder Roles

The implementation of S2N relied on effective coordination between the multiple stakeholders in the state. In addition to BSACS other important stakeholders in the S2N initiative for the state of Bihar were Alliance, Public Health Foundation of India (PHFI), CARE and FHI360. The roles of each are detailed below.

India HIV/AIDS Alliance – was entrusted with the overall responsibility of implementation of S2N in the state. In Bihar, Alliance recruited a Programme Manager and Administrative Assistant at the state level, and four district based Programme Officers. This team received technical support from a Programme Manager M&E, Technical Officer Clinical Services, Advocacy Manager and Financial Analyst based in Hyderabad. Director AIAP provided overall guidance to the project. Alliance partnered with BVHA to operationalize training and mentoring of Non- TI NGOs in the state.

Public Health Foundation of India (PHFI) - was entrusted with the responsibility of extending supportive supervision to provide additional support to the S2N initiative, coordination at National level with NACO and BMGF and at state level with BSACS, SLPs and other stakeholders. Technical consultants for capacity building and programme management regularly visited the state and provided support to the Alliance team.

Family Health International 360 (FHI 360) - supported the strengthening of STI services through trainings of Medical Officers (on syndromic case management, basics of primary HIV/AIDS), Nurses (on

clinic operative guidelines and standards - COGS, on Syphilis screening through ICST and on programme management skills), counsellors (on counselling skills, using the STI counsellors training tool kit) and outreach workers (on TB verbal screening, using the TB tool kit). It also extended on-site supportive supervision, monitoring and mentoring to TI STI clinics.

CARE India - supported the capacity building of community educators and exposure visits for key TI and SACS personnel to learning sites in Andhra Pradesh.

Platforms for Coordination

To ensure smooth operations a Programme Coordination Committee (PCC) was constituted at the state level. The committee members included:

1. Project Director, BSACS
2. Joint Director, TI, BSACS
3. Representatives of BSD and IE divisions, BSACS
4. Regional Director, Alliance India, Andhra Pradesh
5. Alliance India S2N team
6. Representatives from PHFI

The PCC met twice during the S2N period. The overall progress of the initiative and the challenges faced were discussed during these meetings. This forum supported the tailoring of S2N based on the needs of the state. A few initiatives like the condom study were a result of the recommendations made by the forum. The study was geared to understand the condom supply chain mechanism in the state and list factors that affect non- utilisation of condoms by sex workers and MSM in select districts in Bihar. The findings of the study have helped the BSACS identify the gaps between the condom requirement and distribution. The study mapped the supply of condoms from BSACS to the HRG level and was able to identify the strengths and gaps at each level. Additionally, through interviews with HRGs, insights into condom availability, accessibility and usage were gleaned.

"The Quarterly reviews for sites for quality TI were very critical. When in such a short duration we were trying to develop capacities of 5 TI, it was very important that progress was shared periodically. The TI do not get frequent opportunities to meet each other and learn from each other. The review not only gave them an opportunity to learn and grow but also to indulge in some healthy competition!"
- BSACS Official

While the state level programme stakeholders met through the PCC, a strong need was felt to provide a space for interaction among the Quality Sites for review, cross learning and experience sharing. The quarterly review of the 5 sites for Quality TI was instituted based on this need. Stakeholders who were part of these meetings included PDs and PMs of the sites for quality TI and representatives from BSACS, Alliance and PHFI.

In addition to this, the Alliance team based in Patna met with the TI division in SACS on a weekly basis to update them on the progress of the initiative. Representatives from PHFI and FHI360 and POs from the districts also ensured that their visits to Patna included updating the TI division on the project's progress. This ensured that there was regular communication between BSACS and S2N and that challenges and bottlenecks were addressed in time.

Key learnings

1 A multi- stakeholder platform for review and planning ensures the needs and constraints faced by all involved are discussed and constructive strategies developed. It promotes collective ownership.
2 In addition to structured forums for discussions, routine interaction with the key stakeholders serves to ensure follow up of key decisions .

Status at the close of S2N- An overview

Recruitment and Training Status

Table 8: Recruitment and Training Status				
Name of TI	**Designation**	**Number of positions sanctioned**	**Number of positions recruited**	**Number trained**
Bihar Gramin Jagrukta Abhiyan Samiti (Begusarai)	Programme Manager	1	1	1
	Counsellor	1	1	1
	Outreach Worker	5	5	5
	M&E Assistant	1	1	0
	Accounts Assistant	1	1	1
	Peer Educators	17	17	17
Gram Praudyogik Vikas Sansthan (GPVS) (Madhubani)	Programme Manager	1	1	1
	Counsellor	1	1	1
	Outreach Worker	3	3	3
	M&E Assistant	0	0	0
	Accounts Assistant	1	1	1
	Peer Educators	10	10	10

Wama Shakti Wahini (CBO-Muzaffarpur)	Programme Manager	1	1	1
	Counsellor	1	1	1
	Outreach Worker	8	8	8
	M&E Assistant	1	1	1
	Accounts Assistant	1	1	1
	Peer Educators	31	31	31
Nidaan (Patna)	Programme Manager	1	1	1
	Counsellor	1	1	1
	Outreach Worker	2	2	2
	M&E Assistant	0	0	0
	Accounts Assistant	1	1	1
	Peer Educators	8	8	8
Harijan Adiwasi Shikshan Prashikshan Kalyan Sansthan (Purnea)	Programme Manager	1	1	1
	Counsellor	1	1	1
	Outreach Worker	4	4	4
	M&E Assistant	1	1	1
	Accounts Assistant	1	1	1
	Peer Educators	17	17	17

Status on Select Programme Indicators

Table 9: Percentage achievement on select components

TI Name	Outreach Jan-Mar 2014	Condom Distribution Jan-Mar 2014	Clinic Visits Jan-Mar 2014	HIV Testing Oct 13-Mar 14
BGJAS, Begusarai	89	49	77	77
HASPKS, Purnea	77	95	66	74
GVPS, Madhubani	92	88	49	46
Nidaan, Patna	92	57	94	73
WSS, Muzaffarpur	99	93	94	95

The S2N initiative was launched in the northern states with the initial aim to transfer learnings of the Āvāhan programme. At the same time the initiative was open to modification based on the state's requirement. This flexibility has allowed Alliance and BSACS to understand the on-field situation of targeted interventions and tailor the specifics of the S2N initiative to suit it.

At the end of the initiative, as committed to BSACS, the S2N process has facilitated the recruitment, trainings and provided onsite support to all cadres of TI staff in the 5 sites for Quality TI. As of May 2014 all 5 PMs, 5 counsellors, 22 ORWs, 1 M&E assistant (Only 2 TI have sanctioned positions of which 1 was trained), 5 accounts assistants and 83 PEs have been trained by the S2N initiative. All sanctioned positions have been recruited at each site for Quality TI. Clinical infrastructure, drugs and equipment have also been provided to these TIs and the outreach team has been supported with communication tools and aids. A trained and motivated workforce, well supported by infrastructure, is now available at these sites and with continued guidance can develop their TI into sites for learning within the state.

Trainings for all cadres of staff of the 16 other FSW and Core Composite TIs were also completed as scheduled and a pool of non-TI NGOs has also been capacitated to understand the TI programme. This pool can be a significant resource for the expansion of TI coverage within the state. Regular supervision and capacity building programmes can help build on the gains of the S2N initiative and provide an impetus to build a robust TI programme in the state.


KNOWLEDGE TO ACTION
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