

# INDIA FINAL REPORT

October 1997–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



**USAID**  
FROM THE AMERICAN PEOPLE







# India Final Report

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# Acknowledgments

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The Family Health International (FHI) India Country Office would like to dedicate this report in memory of all the people living with HIV, including children, who lost their lives during the decade-long journey of the IMPACT project in India. This report presents glimpses of the achievements, best practices and lessons learned under IMPACT that laid the foundation of FHI's future work in India.

At the outset, we would like to thank the United States Agency for International Development (USAID) for its close engagement, continuous encouragement and funding support. USAID's confidence in FHI's technical expertise and collaborative partnership led to FHI undertaking pioneering work on HIV/AIDS in India, especially for orphans and vulnerable children (OVC) and other marginalized and vulnerable population groups. We acknowledge the long-term partnership and support of the USAID bilateral partners AIDS Prevention and Control (APAC) in Tamil Nadu and The Avert Society in Maharashtra for facilitating the smooth transition of some of the FHI-supported projects beyond IMPACT.

We thank the Government of India, particularly the National AIDS Control Organization (NACO), for giving FHI the opportunity to contribute to the national HIV/AIDS program in India. We also thank the Indian Council for Medical Research (ICMR) for their partnership in various studies undertaken under IMPACT. We acknowledge the collaboration and support of the State AIDS Control Societies of Andhra Pradesh, Delhi, Maharashtra, Mumbai, Manipur, Nagaland and Tamil Nadu.

We appreciate the dedicated efforts of all our nongovernmental organization partners, including networks of people living with HIV/AIDS and other community-based and faith-based organizations, for their willingness to innovate, learn and apply lessons within the demonstration projects supported under IMPACT. I also acknowledge the hard work and contribution of the FHI India team, both staff and consultants, for their commitment to FHI's work under IMPACT over the past decade.

Finally and most importantly, we thank all the children in our OVC projects for their creativity and enthusiasm in designing child participatory approaches and materials, especially the life skills education (LSE) toolkit. The combined experiences and insights of our implementing partners and the communities contributed to the development of a number of innovative tools and resources that are being adapted under similar initiatives supported by FHI.



Kathleen Kay  
**Country Director**  
**Family Health International**  
**India Country Office**

# Glossary of Acronyms

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<b>ABC</b>	Abstinence, Being Faithful and Condom Use
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>APAC</b>	AIDS Prevention and Control Project
<b>ART</b>	Antiretroviral Therapy
<b>BCC</b>	Behavior Change Communication
<b>BSS</b>	Behavioral Surveillance Survey
<b>CBO</b>	Community-Based Organization
<b>CBVCTC</b>	Community-Based Voluntary Counseling and Testing Center
<b>CCDT</b>	Committed Community Development Trust
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHBC</b>	Community and Home-Based Care
<b>CHES</b>	Community Health Education Society
<b>CMIS</b>	Computerized Management Information System
<b>CMM</b>	Community Members
<b>CRS</b>	Catholic Relief Services
<b>DFW</b>	Department of Family Welfare
<b>DLN</b>	District Level Network
<b>ECR</b>	Expanded Comprehensive Response
<b>ECS</b>	Eleutheros Christian Society
<b>FHI</b>	Family Health International
<b>FSW</b>	Female Sex Worker
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GIPA</b>	Greater Involvement of People Living with HIV/AIDS
<b>GOI</b>	Government of India
<b>HBC</b>	Home-Based Care
<b>HIV</b>	Human Immunodeficiency Virus
<b>HST</b>	The Humsafar Trust
<b>IEC</b>	Information, Education and Communication
<b>IMPACT</b>	Implementing AIDS Prevention and Care Project
<b>LSE</b>	Life Skills Education
<b>MIS</b>	Management Information System
<b>MOHFW</b>	Ministry of Health and Family Welfare
<b>MOSJE</b>	Ministry of Social Justice and Empowerment
<b>MSM</b>	Men Who Have Sex with Men
<b>NACO</b>	National AIDS Control Organization
<b>NACP</b>	National AIDS Control Program
<b>NFHS</b>	National Family Health Survey
<b>NGO</b>	Nongovernmental Organization
<b>O/GAC</b>	Office of Global HIV/AIDS Coordinator

<b>OI</b>	Opportunistic Infection
<b>OVC</b>	Orphans and Vulnerable Children
<b>PATH</b>	Program for Appropriate Technology in Health
<b>PCI</b>	Project Concern International
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PLC</b>	Positive Living Center
<b>PLHA</b>	People Living with HIV/AIDS
<b>PPTCT</b>	Prevention of Parent-to-Child Transmission
<b>PWN+</b>	Positive Women's Network
<b>QA/QI</b>	Quality Assurance/Quality Improvement
<b>SACS</b>	State AIDS Control Society
<b>SASO</b>	Social Awareness Service Organization
<b>SBC</b>	Strategic Behavioral Communications
<b>SBT</b>	Salaam Baalak Trust
<b>SFDRT</b>	Society for Development Research and Training
<b>SLN</b>	State Level Network
<b>SOP</b>	Standard Operating Procedures
<b>STI</b>	Sexually Transmitted Infection
<b>SUPPORT</b>	Society for Undertaking Poor People's Onus for Rehabilitation
<b>UNHCR</b>	United Nations High Commission for Refugees
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>USAID</b>	United States Agency for International Development
<b>USG</b>	United States Government
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization

# I. Executive Summary

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USAID awarded Family Health International (FHI) a 10-year cooperative agreement from October 1997 to September 2007 for the global Implementing AIDS Prevention and Care (IMPACT) project. Under this agreement, the USAID India Mission obligated a total of US\$23.6 million to FHI. The IMPACT project in India was developed to support USAID India's program priorities and the National AIDS Control Organization's (NACO) strategic plan. A major focus of the project was to strengthen the capacity of Indian organizations, including the government, nongovernmental organizations, and private and informal sectors, to better respond to the HIV/AIDS epidemic. The IMPACT project developed innovative demonstration projects in underserved program and technical areas so that these projects could be replicated and scaled-up, ultimately contributing to national policy and programming in India.

During IMPACT, FHI developed 63 projects and provided technical assistance to 93 implementing partners working in HIV prevention, care and support for vulnerable, infected and affected population groups. These projects reached a total population of 1,607,561 direct beneficiaries, including 49,455 orphans and vulnerable children (OVC), 17,919 drug users, 36,998 men who have sex with men (MSM), 391,180 migrants, truckers and industrial workers, 41,560 people living with HIV/AIDS (PLHA) and 1,070,459 general community members.

In addition, FHI provided technical assistance in HIV/AIDS research, program management and technical areas to 40 collaborating partners including the government, USAID-supported bilateral partners and other development agencies. FHI's major areas of technical assistance included formative assessments, technical studies, capacity building in program management and technical areas including:

- implementing the Office of the Global AIDS Coordinator (O/GAC) guidelines on abstinence, being faithful and consistent condom use (ABC);
- creating a computerized management information system (CMIS); and
- operationalizing three important cross-cutting themes—gender, greater involvement of people living with HIV/AIDS (GIPA) and reducing stigma and discrimination.

Through its work in India, FHI was instrumental in developing several technical resources that contributed to the improved coverage and quality of the OVC programs in the country. Key resources produced by FHI included: i) a life skills education toolkit; ii) a protocol for counseling, testing and disclosure of HIV status for children; iii) a protocol for detoxification and rehabilitation for substance-using children; and iv) child- and youth-friendly communication materials to promote HIV prevention.

Lessons learned under IMPACT were linked to policy and advocacy work at both the national and state levels and resulted in wider adoption of IMPACT's program approaches and the

leveraging of other resources. Technical assistance to NACO, State AIDS Control Societies (SACS) and government ministries at the national level continued through the end of the IMPACT project. FHI staff and consultants drew on IMPACT experiences and lessons learned to contribute to the design of the third phase of the National AIDS Control Program (2006–2011), the development of national operational guidelines, and expert groups on several technical area issues including OVC, drug users, STI and targeted interventions.

USAID funding under IMPACT enabled FHI and its partners to leverage additional funds for continuation of several innovative project interventions. In doing so, FHI created synergy that led to financial support from the Bill & Melinda Gates Foundation (BMGF) in Mumbai for an HIV prevention project with sex workers and their regular partners, and from the United Kingdom Department of International Development to continue to support a cross-border project with Nepali migrants. The IMPACT OVC program in Andhra Pradesh created the foundation for a larger OVC program with the Children’s Investment Fund Foundation and the Elton John HIV/AIDS Foundation in partnership with the Clinton Foundation and CARE India.

## II. Country Scenario

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India's population of 1.136 billion people (2006)<sup>1</sup> comprises approximately one-sixth of the world's population. According to the Census of India in 2001, India's birth rate of 22.01 births/1,000 population and its death rate of 8.18 deaths/1,000 population contribute to the country's overall population growth rate of 1.38 percent. Although the country has made significant progress in improving the health of its citizens, statistics on India's fertility rates, HIV and other infectious disease burden and child survival rates point to the need for renewed efforts to expand programs, identify new models for intervention and develop approaches to ensure sustainability.

### A. HIV/AIDS Scenario in India

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HIV/AIDS is a serious public health problem affecting India, with the potential to reverse development gains unless HIV prevention and treatment efforts are intensified in both quality and scale. According to the National AIDS Control Society (NACO), India has an estimated 2 million to 3.1 million<sup>2</sup> HIV-positive people, with 0.36 percent adult HIV prevalence rate. These statistics mask substantial variation in HIV prevalence among states coupled with a large differential in rural-urban population and the vulnerability of certain segments of the population—especially women and children. Thirty nine percent<sup>3</sup> of infected persons in the country are women. This indicates an increasing feminization of the epidemic and an accompanying increase in pediatric AIDS. Young adults, ages 15–29, account for 33 percent of AIDS cases.<sup>4</sup> According to 2007 NACO estimates, around 70,000 children under the age of 15 are infected with HIV in India and 21,000 children are infected every year through mother to child transmission.<sup>5</sup>

Nearly 7,500 children<sup>6</sup> are currently receiving antiretroviral therapy (ART) in India. NACO has classified six states as high HIV prevalence states: Karnataka, Andhra Pradesh, Maharashtra, Manipur, Nagaland and Tamil Nadu. Eight states, Uttar Pradesh, Bihar, Rajasthan, Chattisgarh, Jharkhand, Madhya Pradesh, Uttaranchal and Orissa, have been classified as vulnerable due to pockets of high prevalence in some districts, large populations, weak public health infrastructures, low status of women, low literacy levels, poor health indicators and high levels of vulnerability. Of the 611 districts in India, 140 have high HIV prevalence or more than 1 percent of pregnant women testing HIV-positive in antenatal clinics.<sup>7</sup> Rates of sexually transmitted infections (STIs) and HIV infection among most-at-risk populations, including female sex workers, drug users, men who have sex with men (MSM), and truckers and other mobile populations, are high. On average, the HIV prevalence rate among female sex workers is 8.44 percent, among drug users is 10.16 percent and among MSM is 8.74 percent, with considerable

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<sup>1</sup> Census Bureau of India: population estimate for September 1, 2007

<sup>2</sup> UNAIDS/ NACO press release 2007 Epidemichttp://data.unaids.org/pub/PressRelease/2007/070706\_indiapressrelease\_en.pdf

<sup>3</sup> NACO (April 2006), HIV/AIDS Epidemiological Surveillance & Estimation report for the year 2005.

<sup>4</sup> NACO, 2001, Disaggregated data from the National Behavioural Surveillance Survey: KAP of Young Adults (15-24 years)

<sup>5</sup> NACO and MWCD, July 2007. "Policy Framework for Children and AIDS, India"

<sup>6</sup> Clinton Foundation 2007

<sup>7</sup> NACO HIV surveillance survey 2003-2005

differences in the prevalence rates from state to state.<sup>8</sup> Another important source of information on the HIV/AIDS scenario in India is the National Family Health Survey-3 (2005–2006) that was conducted by the Government of India (GOI) in 29 states with support from various partners, including USAID. Based on the findings of the NFHS-3, 80% of married men and 57% of married women between the ages of 15 and 49 had heard of AIDS and around 68% men and 35% women knew that consistent condom use can reduce the chances of acquiring AIDS.

Most HIV infections in India are due to heterosexual transmission. In the Northeast, however, injection drug use is the main mode of transmission. Large-scale population mobility and migration both within and between states further contribute to the spread of disease. Gender prejudice, unequal power in decision making between men and women, and women's inability to negotiate safer sex represent major obstacles to HIV prevention in India.

## **B. Government Response to HIV/AIDS**

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The first case of HIV was documented in India in 1986. In 1987, a National AIDS Control Program (NACP) was established to coordinate the national response. NACP's activities covered surveillance, blood screening and health education.<sup>9</sup> In 1992, the government set-up the National AIDS Control Organization (NACO), to oversee the formulation of policies, prevention work and support programs relating to HIV and AIDS. The first phase of the program, NACPI (1992–1999) focused on generating awareness, strengthening management capacity for HIV/AIDS control, improving blood safety, controlling STIs and building surveillance and clinical management capacity. While significant progress was made in building capacity at the state level, the centralization of planning and implementation led to uneven implementation of project activities. Sentinel surveillance could not be conducted across all states, and issues of PLHA care and support could not be fully addressed.

NACP II (1999–2006) focused on targeted interventions for high-risk groups; prevention strategies through voluntary counseling and testing (VCT) and prevention of parent-to-child transmission (PPTCT); introduction of antiretroviral treatment (ART); and low-cost strategies for care and support. Further, NACP II placed emphasis on institutional strengthening, decentralization of service delivery and management reforms for State AIDS Control Societies (SACS) and intersectoral collaboration. In 2002, the government adopted the National AIDS Prevention and Control Policy to prevent HIV/AIDS from spreading further and to reduce the impact of the epidemic on the general population. In 2006, the Pediatric AIDS Initiative was launched in India. Despite some key successes, the overall scale and scope of the response required substantial scale-up and a rapid decentralization of the national program to the states. The response also required larger state budget allocations and an agenda to build the capacity of local leaders, both in HIV prevention and in ensuring universal access to care, support and treatment services for PLHA. The National AIDS Council, headed by the prime minister, was created in June 2005 with representation from government ministries, nongovernmental organizations (NGOs) and PLHA networks. The council demonstrated the GOI's increasing commitment to strengthen the national program.

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<sup>8</sup> NACO (April 2006), HIV/AIDS Epidemiological Surveillance & Estimation report for the year 2005.

<sup>9</sup> NACO, UNGASS India report: Progress report on the declaration of commitment on HIV/AIDS, 2005.

NACP has entered a critical phase, facing the enormous challenges required for scale-up from phase II to phase III (2006–2011). The third plan, developed through a long, transparent and consultative process adopted by the GOI, includes a threefold increase in the national budget. NACP III aims to scale-up comprehensive services, decentralizing implementation up to the district level, integrating prevention with care, support and treatment, developing public-private partnerships and mainstreaming various activities with other sectors. Further, the plan includes an increased focus on OVC, youth and women; integration with the National Rural Health Mission and other national health programs—notably the Reproductive and Child Health Program and the Revised National Tuberculosis Control Program; capacity building; and stronger monitoring and evaluation (M&E) for evidence-based planning and program implementation. Finally, leadership, capacity building, technical assistance and institutional strengthening in key management and technical areas have been identified as critical strategic approaches to ensure the scale-up of programs in depth and breadth as planned in NACP III.

### **C. Multisectoral Response**

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More than 30 donors currently contribute to the GOI's national response, with USAID acting as one of the main contributors to HIV programs. India receives technical assistance and other support through in-country presence and partnerships with the United Nations: The Joint United Nations Programme on HIV/AIDS (UNAIDS) and its 10 UN co-sponsors—UNICEF, UNHCR, ILO, UNDP, UNFPA, UNESCO, WHO, UNODC, WFP across the UN Theme Group on HIV/AIDS, and the World Bank—and a number of bilateral donors such as the United Kingdom Department for International Development and the Bill & Melinda Gates Foundation. Recent donors include the Children's Investment Fund Foundation and the Clinton Foundation.

### **D. USAID Response to HIV/AIDS in India**

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The U.S. Government (USG) provides bilateral assistance to India for HIV/AIDS and support through its financial contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The USG supports activities in high prevalence states, including Karnataka, Tamil Nadu, Maharashtra, Andhra Pradesh and the Northeast, to improve HIV/AIDS prevention and care for PLHA. USAID's goal is to stabilize or reduce HIV transmission by focusing on behavior change among vulnerable populations and by curtailing the spread of the epidemic to low-risk and rural populations.

USAID has supported activities in India since 1995 and the Centers for Disease Control and Prevention (CDC) has been working in India since 2001. USAID's bilateral HIV/AIDS assistance to the GOI includes the AIDS Prevention and Control (APAC) project in Tamil Nadu and Pondicherry and The Avert Society of Maharashtra (Avert), targeting high-risk behavior groups with HIV prevention interventions. Both projects incorporate care and support activities into their programs and together support more than 130 NGOs in providing HIV/AIDS prevention, care and support activities. In addition to its support of the IMPACT project, USAID provides Population Service International (PSI) with funding for a program in 12 port cities

in eight states, targeting truckers and sex workers in and around ports through interpersonal education, counseling and testing, and STI services. USAID has also taken a lead role in promoting the needs of OVC in India and has supported 30 OVC projects country-wide through the IMPACT project.

In May 2005, India was included as one of the five priority non-focus countries under the President's Emergency Plan for AIDS Relief (PEPFAR). The United States Mission to India has committed its diplomatic resources, technical capacity and HIV/AIDS development assistance to support the GOI, within the framework of NACP III (2006–2011), to stabilize the HIV/AIDS epidemic in India and to achieve key objectives for prevention, treatment, care and support, capacity building, and M&E.

The USG's strategic priorities for 2006–2011 include supporting the third phase of NACP III in achieving its key objectives for prevention, treatment, care and support, capacity building and M&E; operating as a single program that will integrate various HIV/AIDS activities and maximize the strengths of each USG agency; working with other partners and leveraging resources to bring programs to scale; continuing to implement prevention programs for most-at-risk populations in states and districts; promoting a sustainable network model that integrates prevention, treatment, care and support services in the public and private sectors; supporting the GOI to build capacity for policy and program development at the national and state levels; building indigenous capacity for program management and implementation; and implementing programs within the framework of the "Three Ones" principle (i.e., one national authority on HIV/AIDS, one strategic framework and one M&E plan) of UNAIDS and the USG, aimed at coordination and harmonization of the country's response to HIV/AIDS.

In October 2006, USAID launched the US\$49 million Enhance project to contribute to the U.S. Mission's Strategic Objective 14, Intermediate Result Area 2: Increased use of prevention, care and support interventions to prevent/mitigate HIV/AIDS. The Enhance project will support the Karnataka Health Promotion Trust to implement integrated prevention, treatment and support services in the high prevalence state of Karnataka and in the coastal areas of Andhra Pradesh. Through PSI, Enhance is promoting innovative public-private partnerships in an effort to enlist new partners and use the strengths of different groups in society to expand efforts to reduce the spread of HIV/AIDS.

Under Enhance, FHI is providing technical assistance to NACO, GFATM, four key government ministries, SACS in the four USG priority states, USG partners and civil society organizations under the framework of NACP III and PEPFAR, to ensure effectiveness in the implementation of a comprehensive response to the HIV/AIDS epidemic in India. FHI is also providing grant management and technical assistance to four demonstration projects in Delhi that will focus on facility-based palliative care for marginalized drug users and PLHA; community- and home-based care for OVC and their families; prevention of HIV among street and vulnerable youth and children; and prevention of HIV among youth and children, especially adolescent girls in rural Delhi.

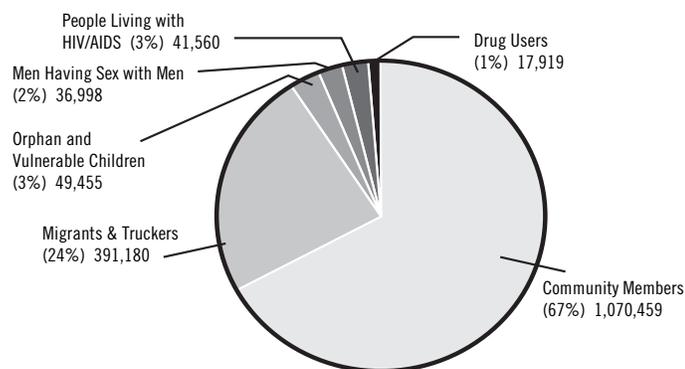
# III. Overview of IMPACT Project in India

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The USAID India Mission obligated a total of US\$23.6 million to FHI for the IMPACT project. The project contributed to the mission in supporting the national response to HIV/AIDS through its strategic objective (SO) to “improve health and reduce fertility in targeted areas of India.” IMPACT contributed to USAID India’s program priorities and NACO’s strategic plan, taking into account USAID’s geographic focus and its bilateral projects, APAC and Avert. The mission developed an HIV/AIDS strategy for 2003–2007 with the SO-level target “to stabilize HIV prevalence in the general population and to reduce HIV prevalence in high-risk groups.” FHI was one of many USAID partners contributing to this strategy, with IMPACT complementing the USAID bilateral projects and the field support programs implemented by other organizations.

Strengthening the capacity of Indian organizations was one of the major focus areas of IMPACT. FHI worked to build the capacity of the government and NGOs as well as India’s private and informal sectors to respond to the HIV/AIDS epidemic. IMPACT developed innovative demonstration projects in several underserved program and technical areas to replicate and scale-up these projects, which ultimately contributed to national policy and programming in India. The IMPACT India project evolved over the years based on lessons learned from collective global and India-specific experiences in HIV/STI prevention and care to respond more effectively to the changing nature of the pandemic.

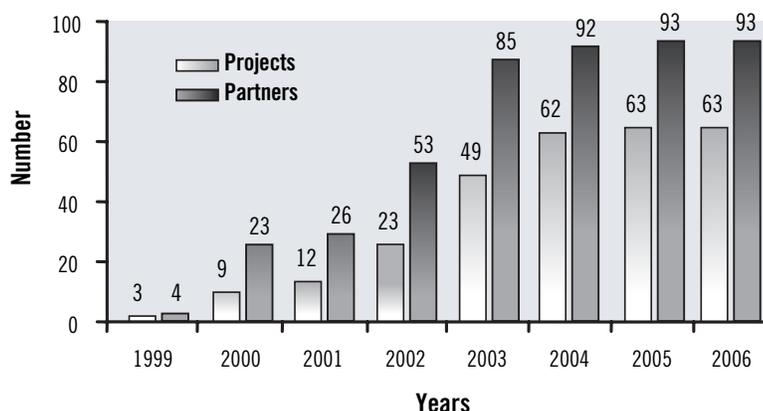
**Figure 1. Direct Service Beneficiaries Reached Under Impact 1999–2006**



From four implementing partners in 1999, USAID/FHI grew to support 63 projects and provided technical assistance to 93 implementing partners in six states: Andhra Pradesh, Delhi, Maharashtra, Manipur, Nagaland, Tamil Nadu and the union territory of Pondicherry (see figures 1 and 2). FHI’s implementing partners ranged from small to medium NGOs to faith-based organizations (FBOs) and community-based organizations (CBOs). In addition, FHI provided technical assistance in HIV/AIDS research, program management and technical areas to nearly 40 collaborating partners, including the government, USAID-supported bilateral partners and other development agencies.

As shown in Figure 1, FHI’s IMPACT project in India reached a total of 1,607,561 direct beneficiaries (through September 2006) including 49,455 OVC (3 percent), 17,919 drug users (1 percent), 36,998 MSM (2 percent), 391,180 migrants, truckers and industrial workers (24 percent), 41,560 PLHA (3 percent) and 1,070,459 other community members (67 percent).

**Figure 2. Number of Projects and Implementing Partners Under IMPACT: 1999–2006**



## **A. Strategic Approach**

The strategic approach of the IMPACT project in India consisted of:

- a. Supporting the capacity strengthening of Indian organizations including government, USAID-supported bilateral partners and local organizations
- b. Developing innovative demonstration projects in underserved areas as learning sites to influence national policy and programs in India

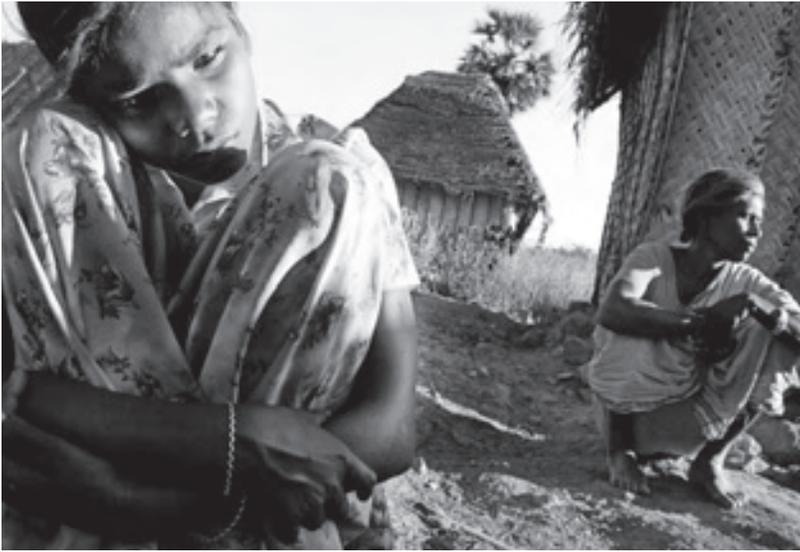
## **B. Chronological Evolution**

### **1997–1999: Start-up**

In the beginning, FHI’s IMPACT project focused on complementing the work of two USAID bilateral partners, APAC in Tamil Nadu and Avert in Maharashtra, while providing technical support to NACO and the SACS. Technical support was provided by international and national consultants as well as FHI staff from FHI’s Asia Pacific Regional Office. FHI provided technical assistance in a wide range of technical areas including behavior surveillance studies, formative assessments and technical studies to build knowledge and understanding of the HIV epidemic. In early 1999, FHI/IMPACT established a small project office with two staff in Mumbai, Maharashtra. The Mumbai office coordinated and monitored five research studies for the Avert project and facilitated technical assistance requests.

### **2000–2001: Developing Demonstration Projects**

In 2000, FHI began supporting five demonstration projects addressing OVC, MSM and home-based care and support issues (see details in Annex). At that time, NACP II focused on HIV prevention and primarily supported targeted interventions for high-risk groups including sex workers and truckers. Vulnerable and other at-risk population groups such as OVC, MSM and drug users were underserved. Further, the programs did not address the comprehensive prevention, care, support and treatment needs of those infected with or affected by HIV. Recognizing these gaps, FHI drew on its experience in other countries to develop demonstration projects in India using innovative strategies. These projects served as learning sites and were later replicated and expanded



Twelve-year-old Purnima, seen here with her blind grandmother outside their thatched hut, was the first client of Paramthi Vellore Positive Living Center (PLC). With support from the PLC project she has been able to overcome the stigma and discrimination she faced in her village. USAID/FHI supported the Indian Network for People Living with HIV/AIDS (INP+) through the district network partner HIV Ullor Nala Sangam (HUNS) to implement the PLC project, which provides comprehensive HIV prevention, care and support services to PLHA in Namakkal district, Tamil Nadu.

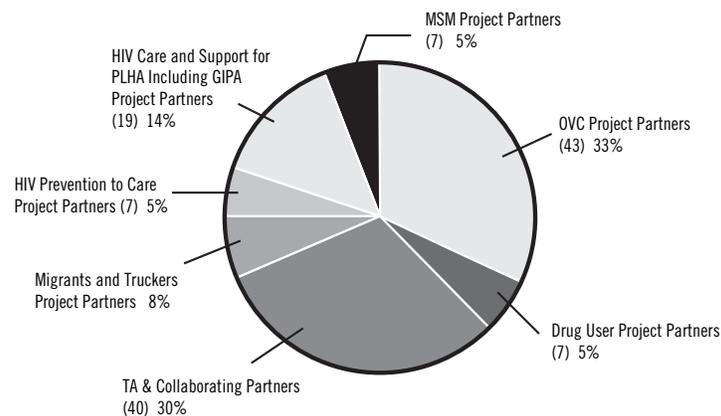
under the national program. A larger FHI India Country Office, headed by a Country Director, opened in December 2001 in New Delhi.

### **2002–2005: Scaling-Up**

As the USAID mission in India developed an HIV/AIDS strategy, FHI's role in both technical assistance and grants management increased substantially. Under the mission strategy, FHI scaled-up technical assistance at both the national and state levels. FHI also expanded demonstration projects in areas that were not covered in the national program nor reached through the bilateral projects. FHI initially conducted situation assessments followed by meetings with key stakeholders to identify the needs of key target populations. Potential organizations were identified through referral networks, assessments studies and consultations with community members. Implementing partners were selected on the basis of an organizational assessment using established criteria (including experience implementing HIV programs; management systems; potential skills and experience in a specific area; ability to scale-up; and legal status). Between 2004 and 2005, additional regional offices were opened in Chennai (Tamil Nadu) and Hyderabad (Andhra Pradesh), which enabled FHI to work more closely with implementing partners by providing frequent site visits and technical assistance.

The IMPACT project targeted underserved OVC populations and developed demonstration projects as learning sites with groups considered important bridge populations for the HIV epidemic in India, including MSM, drug users, migrant and mobile populations. The demonstration projects were replicated by other funders, and lessons learned at these sites informed strategic planning. Three cross-cutting themes were integrated into all intervention projects through the development of a behavior change communication (BCC) strategy that included: addressing stigma and discrimination; greater involvement of people living with HIV/AIDS (GIPA); and gender empowerment. Through grants management, FHI built the capacity of 93 implementing partners in a range of areas from participatory proposal writing and financial and program management to quality assurance (QA) in HIV/AIDS technical areas. A breakdown of the project partners by their area of technical expertise is shown in Figure 3.

**Figure 3. Partnership Under IMPACT: 1999–2006**



In addition to ongoing technical assistance partnerships with APAC and Avert, FHI initiated collaborative projects with NACO in innovative technical areas including migration and drug use. In Tamil Nadu, technical assistance to the Tamil Nadu State AIDS Control Society (TANSACS) focused on building an expanded comprehensive response (ECR) within high HIV prevalence districts. District action plans were developed in the high prevalence districts of Namakkal and Tirunelveli in Tamil Nadu. Over the years, FHI was requested by USAID and the GOI to provide technical assistance (TA) to NACO, SACS, the Ministry of Social Justice and Empowerment, the Department of Family Welfare, APAC, Avert and a wide range of USAID partners in a variety of HIV/AIDS programs as well as technical and research areas.

### **2006–2007: Transitioning and Sustainability**

In 2005, the IMPACT cooperative agreement ceiling was reached, which restricted the level of funds that the U.S. Mission in India could obligate under IMPACT. As a result, instead of scaling-up, FHI had to transition NGO projects from USAID funding to other sources earlier than expected. A total of 22 OVC projects were funded jointly under IMPACT and the USAID-supported YouthNet program from October 2005 through June 2006, and then extended under IMPACT to the end of September 2006. All other projects were extended to September 30, 2006, 12 months before the final closeout of IMPACT in India.

Several approaches were adopted to enhance the likelihood of project sustainability after IMPACT, including actively involving community members in programs through activities such as community volunteering and peer education; building linkages with appropriate government and NGO programs; and transitioning select projects to APAC and Avert in Tamil Nadu and Maharashtra. One of the most important steps FHI took to prepare partners to continue operations was providing technical assistance in proposal development so that these organizations were able to seek alternate sources of funding. FHI also helped identify new resource development opportunities, which in several cases led to additional project funding.

FHI conducted participatory end-of-project reviews of all projects, and a few projects were selected for outcome evaluations. Detailed end-of-project review reports were prepared and partners



Substance-using street children and youth attend a non-formal education class at a drug rehabilitation center. With funding from USAID, FHI provided grant support and technical assistance to SUPPORT, a nongovernmental organization, to implement a project in Mumbai beginning 2002 to enable substance-using street youth and children reduce their vulnerability to HIV and substance use.

organized a series of project-level dissemination meetings. FHI continued to provide technical assistance to NACO, SACS and government ministries at the national level through the end of IMPACT with FHI staff and consultants drawing on IMPACT lessons learned to contribute to the NACP III design. FHI experiences also played an important role in the development of national operational guidelines, as FHI participated in several expert technical groups dealing with OVC, drug users, STIs and targeted interventions.

USAID funding under IMPACT allowed FHI and its partners to leverage additional funding. FHI created synergies between USAID funding and support from the Bill & Melinda Gates Foundation in Mumbai and leveraged funding from the UK Department for International Development to implement a cross-border project with Nepali migrants. The IMPACT OVC program in Andhra Pradesh provided the foundation for a larger OVC program with the Children's Investment Fund Foundation and the Elton John HIV/AIDS Foundation in partnership with the Clinton Foundation and CARE India.

### **C. Management and Staffing**

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Although the IMPACT project began in 1997, FHI's program in India expanded most rapidly from 2002 to 2005. The FHI India staff grew from two staff members in 1999 to 34 in 2004-2005. This team included a highly trained and competent group of program, technical, finance and administrative staff members. FHI provided ongoing team training in program planning, project design, managing subagreements, financial management, management information systems (MIS) and HIV/AIDS technical areas. The FHI India Country Office was decentralized in May 2003 when FHI headquarters delegated authority to the Country Director to execute subagreements up to US\$750,000.

# IV. Program Implementation and Results

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## A. Demonstration Projects

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Demonstration projects were supported under the following categories:

- i) Orphans and vulnerable children (OVC)
- ii) Drug users
- iii) Men who have sex with men (MSM)
- iv) Migrants, mobile populations and workplace populations
- v) Comprehensive HIV prevention-to-care interventions in high HIV prevalence districts
- vi) HIV care and support for PLHA including GIPA

### i) Orphans and Vulnerable Children

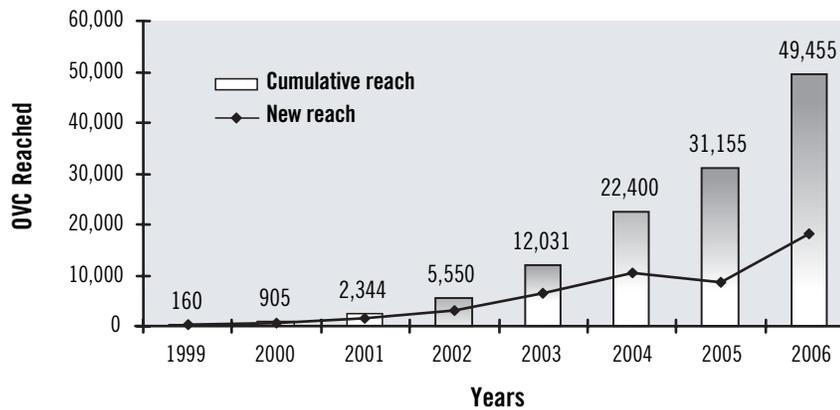
In 1999, FHI was one of the pioneering organizations in India to link OVC and HIV/AIDS by addressing the needs of children living with, affected by and vulnerable to HIV/AIDS. Situation assessment studies revealed numerous runaway and street children, children of sex workers and children living in abusive conditions and at-risk of HIV infection. FHI's OVC activities began in the midst of a number of challenges and constraints. The government's response to HIV/AIDS did not include OVC and was limited to targeted interventions with adult high-risk population groups; there was a lack of data on the number of orphans and HIV-affected children; and the capacity of NGOs working with children was limited, especially in HIV/AIDS programming. With a special funding allocation from the U.S. Congress, six demonstration projects were initiated in 1999-2000 in Delhi, Mumbai, Chennai and Pondicherry.

In 2002, FHI conducted a situational assessment in two high prevalence states that revealed a large unmet need for comprehensive care and support services for children living with and affected by HIV, especially in high prevalence districts. There was also growing commitment from USAID



Sanjay, Anurag and Rahul ran away from home and ended up at the New Delhi Railway Station. They were identified by peer educators from Salaam Baalak Trust, an NGO working with street and working children in central Delhi, and were motivated to join the Government Railway Police Centre run by Salaam Baalak Trust. Two years later, they started working as peer educators for the center while also accessing educational and healthcare services. They earn a living at the station selling newspapers and cleaning trains. Salaam Baalak Trust was supported by USAID/FHI from September 1999 to September 2006 to reduce the HIV/AIDS vulnerability of street and runaway children. The project is currently being supported by USAID under the SAMARTH project with FHI (2006 – 2011).

**Figure 4. Number of OVC Reached Under IMPACT from 1999–2006**



to scale-up OVC programs in the country to influence policy and programs for children. From supporting six demonstration OVC projects in 1999-2000, USAID/FHI expanded to supporting 34 OVC projects with 52 implementing partners (including nine comprehensive HIV prevention-to-care project partners) in the states of Delhi, Maharashtra, Tamil Nadu, Andhra Pradesh, Manipur and Nagaland. More than 49,455 children and youth at risk, HIV-positive, affected or orphaned by HIV/AIDS, 490,415 community members and 3,971 PLHA were direct beneficiaries of these special services. The growth in the number of OVC reached is shown in Figure 4.

USAID/FHI's OVC program in India included a mix of projects that primarily focused on HIV prevention among vulnerable children—especially street, working and slum children, and children of sex workers—and HIV care and support for infected and affected children. Innovative projects were initiated with groups of children who had not been reached before in HIV programming—for example, substance-using street children and youth.

#### **From a life of “brown sugar” to resuming education...**

Sanjay is a 16-year-old boy from Sholapur, Maharashtra, who lived with his mother, brother and sister. His mother admitted him and his brother to a boarding school in Pune. He started chewing tobacco with his friends while at school, ran away due to fear of being punished and found his way to the streets in Mumbai. Peers on the street offered him a solution (glue) which appeared attractive and gave him a “kick.” Slowly he started chasing brown sugar (low-grade heroin) with the older boys on the streets and began stealing to keep up his habit. Once he was beaten up on the street and sent to the Children's Home. After some time, he ran away. He returned to his old home and started to steal from the railway yards. He also started taking sleeping tablets along with brown sugar as advised by his friend. One day, some of his street friends showed him the day-care center run by SUPPORT (an NGO supported under USAID/IMPACT) and he started going there to play and eat. Eventually, he agreed to opt for detoxification at SUPPORT and was brought to the detoxification center. One day, a man who claimed to be his father came to the center and took him away. The day-care center staff followed up and found him living on the streets and using substances again. The SUPPORT staff motivated Sanjay to return to the center and recommence detoxification. During rehabilitation, Sanjay regularly interacted with the staff and role model peer educators and shared his feelings with them. The staff and peer educators motivated and encouraged him to lead a healthy life free of drugs. Sanjay began to actively participate in extracurricular activities at the center, such as dancing and singing. Now Sanjay is going to school and is studying in the fifth grade.



Sixteen-year-old Sanju, formerly a substance-using street youth, and peer educators provide medical aid to another street child at a drug rehabilitation center. With funding from USAID, FHI provided grant support and technical assistance to SUPPORT, a nongovernmental organization, to implement a project in 2002 to enable substance-using street youths and children in Mumbai to reduce their vulnerability to HIV and substance use.

The OVC programs focused on the following key strategies:

- Using child participatory approaches and child-centered communication, including life skills education and counseling, to reduce vulnerability of children to HIV/AIDS and help them develop skills to cope with their own HIV infection as well as HIV-positive parents.
- Providing care and support services to HIV-infected and -affected children and their families through community-based and home-based care approaches. Services included psychosocial support, clinical care, nutrition, education, household economic strengthening and legal support.
- Linkages to support services including medical, psychosocial and economic support, succession planning and foster care.
- Addressing stigma and discrimination through sensitization of community leaders and community mobilization.
- Capacity building of governmental and nongovernmental agencies in technical and program management areas to support OVC programming using tools developed by FHI in life skills education, counseling, detoxification and child communication.
- Advocacy to influence policy and programs to address the needs of OVC, including pediatric ART, operational guidelines for children infected with HIV and a multisectoral response to meet the development and welfare needs of children.



A group of adolescent girls and boys receive nutritional support at the Young Women's Christian Association (YWCA) of Delhi Family Service Center. The center also provides health services and psychosocial support. From September 2002 to September 2006, USAID/FHI supported the YWCA of Delhi to reduce the vulnerability of street and working children in the urban slums of the Najafgarh area in west Delhi. This center is currently supported under the USAID SAMARTH project with FHI (2006 – 2011).

Over the years, the OVC program strategy evolved from focusing only on the child and primarily on HIV prevention to including comprehensive HIV prevention and care addressing the family as a unit and involving communities as a whole. FHI's efforts focused on providing support to families and communities to ensure that HIV-positive or affected children have equal access to essential services and that they live and grow up in protective environments. This approach also addressed stigma and discrimination. FHI was instrumental in increasing coverage of the OVC program by integrating HIV/AIDS services into existing child and community development programs. FHI further contributed to improving the coverage and quality of OVC programs through the integration of three innovative child-centered interventions: life skills education (LSE), counseling, and detoxification for substance-using children.

These interventions resulted in the development of four technical resources for children (described in detail under Section IV B. on technical assistance):

- i) Life skills education (LSE) toolkit for OVC in India
- ii) Protocol for child counseling on HIV testing, disclosure and support
- iii) Protocol for detoxification and rehabilitation for substance-using children
- iv) Child- and youth-friendly communication materials to promote HIV prevention

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*“We have a transit home for orphan children. Several have HIV and many have died. It is very difficult to hide death from other children, but it is equally difficult to talk about it. There are questions, trauma and insecurity. How do we handle that? How much do we tell children? How do we give them hope?”*  
– Counselor, Chennai

In response to these questions, FHI developed the Protocol for Counseling, Testing and Disclosure of HIV Status for Children and the LSE toolkit.



Adolescent boys and girls are involved in a participatory activity as part of the LSE sessions conducted at St. Paul's Trust, Andhra Pradesh. This session is called "Relationship Maps," and the activity helps adolescents and children understand and deal with various relationships in a positive manner. Sessions are adapted from the LSE toolkit developed by FHI under IMPACT.

One of FHI's key successes was supporting implementing partners to expand services to include community-based and home-based care options for children and families living with HIV/AIDS, rather than focusing exclusively on institutional care.

### **CHES shifts from institution-based to comprehensive HIV care and support for children living with HIV/AIDS.**

USAID/FHI began supporting the Community Health Education Society (CHES) to implement an OVC intervention project in Chennai in 2000 that was focused on a care home for children. With technical assistance from FHI, CHES moved toward community-based and community-led approaches. FHI provided training in community-based and home-based care with a focus on pediatric care that strengthened the medical, nutritional and psychosocial services provided to children and communities. Realizing the value of community-based approaches, CHES started to strengthen the capacities of families, mobilizing and strengthening community responses to create a supportive environment for children living with HIV/AIDS. CHES also introduced foster care, adoption and succession planning within their program. The components included counseling for HIV-positive parents on serostatus disclosure to children; creation of “memory books”; support in appointing standby guardians; legal, educational and psychosocial support and counseling; and medical and nutritional support. Succession planning was introduced for HIV-positive parents, their children and standby guardians and has been valuable in preventing orphaning and ensuring that children have secure futures and opportunities after the death of their parents. CHES referred children for adoption who were found not to be living with HIV/AIDS. The community sensitization efforts have reduced stigma and discrimination against children living with HIV/AIDS and created a supportive environment. CHES had reached a total of 1,059 HIV-infected or affected children as of September 2006.

By implementing the largest OVC program in India, FHI has played an instrumental role in advocating for inclusion of OVC in the third phase of the national program (NACP III). At the request of the National AIDS Control Organization (NACO), FHI became the lead technical assistance agency in the development of the national operational guidelines for children infected with and affected by HIV/AIDS. FHI and its partner agencies, together with UNICEF and the Clinton Foundation, actively advocated with NACO for the introduction of ART pediatric formulations, which contributed to the introduction of pediatric ART within the national ART program in December 2006. In the interim period, FHI collaborated with the Clinton Foundation to make ART pediatric formulations accessible to children living with HIV through FHI’s partner agencies. FHI has leveraged growing interest in OVC issues in India among various donors in the country. The Children’s Investment Fund Foundation has supported a new initiative, Balasahyoga, which translates as *active support to the child*. Balasahyoga is a US\$14 million collaborative program between FHI, the Clinton Foundation and CARE India to scale-up HIV prevention, care and treatment services in 11 districts in the state of Andhra Pradesh. The program will reach 30,000 HIV-affected households, 60,000 children and 60,000 adults over a five-year period (2007 to 2012).



Children participate in a children’s club meeting in Namakkal district, Tamil Nadu, while looking at a nutritious food chart displayed by Prema, a community health nurse. Prema is teaching children infected with and affected by HIV about the value of nutritious food and vitamins. With USAID/FHI support, the Women’s Organization in Rural Development (WORD), in partnership with the Community Health Education Society (CHES), implemented a community-based HIV prevention and care project from December 2003 to September 2006 to minimize the impact of HIV/AIDS among children and their families in Namakkal district.

## **ii) Drug Users**

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The national behavioral surveillance survey (BSS) in 2002 reported that in the Northeast states, 55.3 percent of drug users had shared syringes and needles the last time they used drugs and 23 percent had sex with commercial sex partners during the previous 12 months. The rates of consistent condom use with commercial partners and non-regular partners were 34 percent and 14 percent respectively. The transmission of HIV infection from drug users to their non-using partners has also increased over time. A study carried out in 1997 showed HIV prevalence of 45 percent among non-using wives (Panda et al., 2000). Approximately 3 percent of antenatal clinic attendees in Imphal tested HIV-positive, indicating sexual transmission of HIV in the general population in Manipur (Sentinel Surveillance 2002).

In mid-2002, USAID and NACO requested that FHI work with drug users to support evidence-based policies and programs on drug use issues in India. Working with drug users in the country involved addressing several challenges and constraints. The spread of HIV is exacerbated in the Northeast states due to difficult terrain, remoteness, developmental disparities, militancy by groups demanding independent status for the Northeast states, poor law and order conditions that disrupt lives, and a porous international border that is used for drug trafficking. In addition, there are few NGOs working on drug issues and there exists a divergent sub-population including: street-based drug users in Delhi; married and home-based drug users in Chennai; and young, unemployed youth in the Northeast. These conditions necessitated different strategic approaches to reduce vulnerabilities. USAID funding for drug users primarily focused on research, demonstration of effective drug user interventions, and partner agency capacity building in comprehensive HIV/AIDS and sexual health programs for drug users and their partners. FHI followed USG policies when working with drug users. USAID funds were not used for purchase of needles and syringes.

In 2002-2003, FHI conducted mapping and size estimation studies with NACO and the Indian Council of Medical Research (ICMR) in the five Northeast states (Manipur, Nagaland, Mizoram, Assam and Meghalaya) to gain understanding of the epidemiology and determinants of the HIV epidemic in Northeast India and inform programs and policies. From 2003 onward, FHI collaborated with seven implementing partners and supported six projects that provided a continuum of care for drug users and their sexual partners in rural and urban settings in four diverse Indian states: Tamil Nadu (South India), Delhi (North India), Manipur and Nagaland (Northeast India). The projects targeted drug users in lower socioeconomic groups, including street-based users and those in family settings. This was the first time in India that organizations working on drug issues started to develop projects to address the diverse needs of drug users and their sexual partners.

The key strategies in the demonstration projects for drug users included:

- Undertaking strategic behavioral communications (SBC) through peer-led outreach by recovered drug users.
- Addressing the sexual health of drug users and their partners.
- Providing short-term residential care for recovering drug users needing clinical services including abscess management.



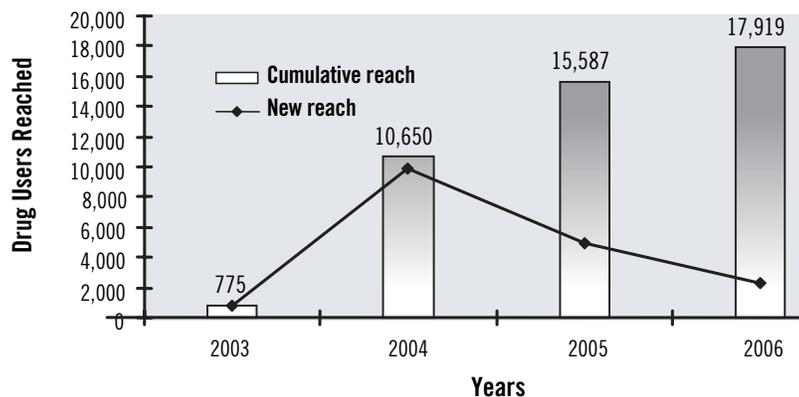
Ashang and his wife, Hormila, are living with HIV in Imphal, Manipur state. They receive home-based care from outreach staff of the Social Awareness Service Organization (SASO). USAID/FHI provided support to SASO from July 2003 to September 2006 for provision of HIV prevention, care and support services to drug users and people living with HIV.

- Meeting the care and support needs of drug users living with HIV/AIDS, including psychosocial support, clinical and palliative care, socioeconomic and legal support.
- Establishing referrals and linkages for HIV counseling and testing, treatment including ART, and rehabilitation and mainstreaming of recovered drug users.
- Sensitizing and advocating with healthcare providers, law enforcement agencies including the police, and other key community stakeholders to address stigma and discrimination and to ensure access to quality services.
- Building capacity of NGOs, community-based organizations (CBOs) and faith-based organizations (FBOs) in technical and program management areas.

FHI collaborated with Sahai Trust in Chennai; Sahara in Delhi; the Social Awareness Service Organization (SASO) in Manipur; and Eleutheros Christian Society (ECS) in Nagaland to implement demonstration projects for drug users and their sexual partners.

FHI supported seven implementing partners for six projects that reached 17,919 drug users, 10,584 community members and 911 PLHA. The growth in coverage of drug users under IMPACT is shown in Figure 5.

**Figure 5. Drug Users Reached Under IMPACT: 2003 – 2006**



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## Reaching drug users living with HIV/AIDS in remote Nagaland (Northeast India)

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Eleutheros Christian Society (ECS) is an NGO based in the Tuensang district of Nagaland (one of eight Northeast states of India). Tuensang is a very remote district, sharing the border with Myanmar. There is an inflow of heroin and other opioid substances from Myanmar to Tuensang, which is then trafficked to other parts of South Asia. The NACO sentinel surveillance report of 2002 showed an HIV prevalence rate of 8 percent among antenatal clinic (ANC) attendees in the district.

The USAID/FHI-supported ECS project is a unique example of involving community organizations, especially FBOs, in the provision of HIV prevention and care services for drug users, their sex partners, youth and OVC residing primarily in rural settings. Between March 2004 and September 2006, ECS, through its network with FBOs including church councils, tribal councils and self-help groups (SHGs), provided services including voluntary counseling and testing (VCT) and prevention of parent-to-child transmission (PPTCT) to about 1,330 drug users, 956 PLHA and their affected families.

Key interventions supported under the ECS project included:

- **HIV prevention outreach to drug users and their sexual partners:** Services included BCC, condom promotion, motivation for addiction treatment and voluntary and confidential testing for HIV.
- **BCC camps:** ECS, in close association with Churches Alliance, organized short-term de-addiction camps for drug users. These camps were held for 7 to 10 days, during which risk associated with drug use, including STI/HIV, was discussed in detail. Most drug users, after attending the BCC camps, joined the ECS rehabilitation program.
- **Primary healthcare:** The clinic at ECS supported under the project provided primary healthcare services including abscess management, treatment of STIs, VCT and treatment of opportunistic infections (OIs) including routine cotrimoxazole prophylaxis.
- **HIV care and support:** ECS adopted a mix of home-based, clinic-based and referral approaches to extend care and support services that included psychosocial support, nutrition support, provision of home-care kits, training in self-care, training of caregivers and referral for ART and treatment of OIs.
- **Empowering OVC:** The project reached youth and children vulnerable to, infected with or affected by HIV/AIDS through a LSE program and formation of youth support groups.
- **Community mobilization and advocacy:** The project emphasized capacity strengthening of women SHGs, sensitization and networking with churches, tribal councils, and government health and medical departments for improved access to quality services, reduction in stigma and discrimination, and effective response to HIV prevention, care and treatment for drug users and PLHA.

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### iii) Men Who Have Sex with Men (MSM)

Under Section 377 of the Indian Penal Code, framed in 1862, homosexuality is considered an unnatural offence and described as “carnal intercourse against the order of nature.” In 2001, when FHI initiated work with MSM in India, few organizations were working to reduce MSM vulnerability to HIV/AIDS. At the time, NACO was supporting only a few traditional targeted interventions. FHI supported demonstration projects to pilot innovative approaches relevant to the Indian context. One challenge was the need to develop innovative risk reduction strategies to reach the large and essentially invisible MSM population in India. There was also a lack of accurate size estimates for measuring coverage. Most agencies working on MSM issues were CBOs with limited capacity to manage HIV prevention and care interventions. FHI’s work addressing the special needs of MSM began with the support of two HIV prevention projects with The Humsafar Trust in Mumbai (Maharashtra state) and Prakriti-Snehidan in Pondicherry (Tamil Nadu state). These initial projects focused on SBC, STI treatment and condom promotion through peer-led outreach. In 2003, with national estimates showing a growing number of MSM and transgenders living with HIV, FHI expanded the scope of its MSM interventions to include comprehensive HIV prevention and care.

The key strategic approaches in MSM and transgender projects included:

- Strengthening CBO institutional capacity to improve access to comprehensive HIV prevention



Villy Chhetri, a nurse working at “Trinity,” Sahara’s Crisis Care Centre and Ahal Hanghal (male behind), health care worker, are attending to the wounds of a drug user who is undergoing the detoxification process at the Sahara Centre located in North Delhi. The project provided drug users with detoxification, abscess management, STI treatment and other emergency health care services and was supported by USAID/FHI from December 2004 to September 2006.

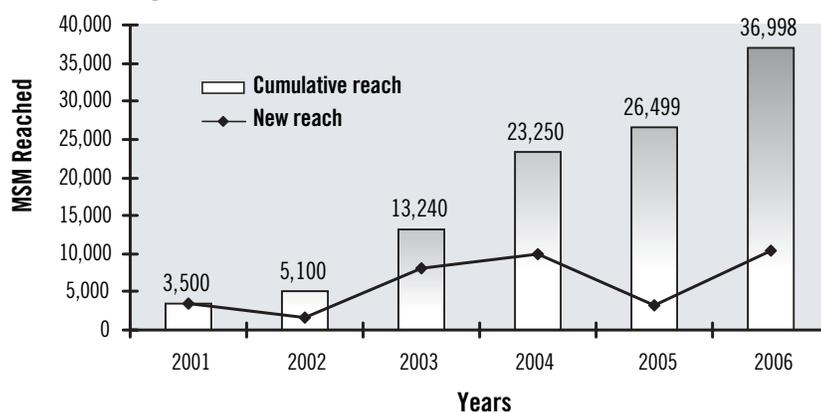
and care services for MSM and transgender populations.

- Addressing risk behaviors in the context of diverse sexual and gender identities, including reaching the partners of MSM.
- Setting-up safe space centers to serve as hubs for SBC focusing on healthy sexual attitudes and behavior, condom programming and STI management.
- Building capacity of healthcare providers in the private and public sectors to diagnose and manage ano-rectal STIs.
- Piloting innovative models for increasing access to VCT for MSM and transgender populations.
- Integrating care and support services including access to treatment (ART) for MSM and transgenders living with HIV.
- Building the capacity of CBOs and NGOs working on MSM and transgender issues to develop comprehensive prevention-to-care programming.
- Sensitizing key stakeholders, including healthcare providers and law enforcement agencies, to improve access to quality HIV prevention and care services.
- Creating an enabling environment through advocacy and networking to build awareness about diverse sexual orientations, begin the process of creating a nonjudgmental environment and reduce stigma and discrimination.



Men who have sex with men (MSM) register at the drop-in center at The Humsafar Trust (HST). With funding from USAID, FHI supported HST, a community-based organization, to implement comprehensive HIV prevention, care and support services for more than 18,000 MSM and transgenders, beginning in October 2001 through September 2006.

**Figure 6. MSM Reached Under IMPACT: 2001 – 2006**



FHI supported a total of four MSM and transgender projects with seven implementing partners, which reached a total of approximately 37,000 MSM and transgenders and 23,206 other community members. The growth in coverage of MSM reached under IMPACT is shown in Figure 6.

In June 2003, to expand coverage of MSM interventions, FHI conducted a situational assessment in Chennai that identified the need for comprehensive interventions with MSM and also identified potential agencies to implement projects among MSM and hijra (transgender) communities. The assessment report recommended Sahodaran and the Social Welfare Association for Men (SWAM) in Chennai as potential partner agencies. FHI supported two comprehensive HIV prevention-to-care projects with these CBOs and used the mentoring organization approach to help develop the capacity of the organizations, which were small and had limited organizational and staff capacity. FHI helped build their organizational and technical capacity and enabled them to develop an independent organizational identity. Given their increased capacity, both Sahodaran and SWAM eventually transitioned to the USAID-supported bilateral project APAC in Tamil Nadu.

### **The Humsafar Trust (HST) leads the way ...**

The achievements of the HST project include an increase in health-seeking behavior among MSM and a model STI clinic offering a holistic package of services including HIV testing services run by HST. USAID/FHI provided support to the clinic, including training of the health staff. This helped MSM to access higher quality health services in settings that they felt comfortable with, resulting in an increase in the numbers of MSM accessing and seeking HIV testing and care and treatment services. Another major achievement was the development of a public-private partnership between HST and the government hospitals. A trained HST health worker and counselor were placed at a government hospital to help make its services more MSM-friendly. This activity also bridged the gap between HIV prevention and care. USAID/FHI support helped HST to scale-up its services and increase coverage of the MSM population in Mumbai with a focus on condom promotion, SBC, STI treatment, and referral for care and treatment services. FHI supported HST for capacity building of other CBOs working on MSM issues in India. HST is an active member of the India Network for Sexual Minorities (INFOSEM), a network of organizations working on MSM issues. HST has contributed significantly to the development of INFOSEM that has provided an existing network for rapid scaling-up of MSM interventions under NACP III. From October 2001 to September 2006, HST reached a total of 18,160 MSM and transgenders with HIV prevention, care and support services.

The major activities of the projects included conducting outreach and HIV prevention activities using the peer education approach; establishing drop-in centers as safe space; setting-up support groups and social meetings that concentrated on community building and psychosocial support; providing STI counseling and treatment services; building the capacity of healthcare providers, especially in STI management; creating an enabling environment to reduce stigma and discrimination; and strengthening organizational and staff capacity for effective program management.

The FHI-supported MSM and transgender projects demonstrated innovative approaches to comprehensive HIV programming that resulted in leveraging funding for scale-up from other donors, including the Bill & Melinda Gates Foundation and Avert. As a result of these innovative projects, FHI and its implementing partners were invited to share best practices and lessons learned in national and international fora. The FHI-supported partner The Humsafar Trust is part of the MSM working group for the NACP III planning process. This working group is developing national operational guidelines for MSM programming.

#### **iv) Migrants, Mobile Population and Workplace Populations**

Research into highly mobile groups such as truckers and migrants in India indicates that these populations are particularly at-risk of HIV due to a number of factors such as high-risk sexual behaviors, lack of information and poor availability of services. Per a 2001 study, at least 25 percent of truckers had used the services of sex workers or had non-regular partners (Source: NACO, BSS Study 2001). Mobile populations and migrants often engage in high-risk behaviors such as unsafe sexual practices with sex workers, and often have less access to HIV information, health services, condoms and STI treatment due to the composition of the migrant populations, cultural/linguistic barriers, instability and unfamiliarity with the community.

In 2002, when FHI initiated projects with migrants and mobile population groups in India, migration projects were not addressing the vulnerabilities of migrant populations through all the stages of the migration cycle, including pre-departure, departure, transit, destination and reintegration. The “tracking” of migrants from source, transit and destination was a difficult proposition. On the other hand, workplace projects were designed primarily as targeted



Truck drivers are counseled by Dr. Rama Rao, the project doctor at a mobile STI clinic at the truck halt hub. Supported by USAID/FHI, the project was a collaborative venture between the All India Motor Transport Congress Society (AIMTCS) and a lorry owners association in the Krishna district of Andhra Pradesh. Since 2002, the project has provided comprehensive HIV prevention and care services to more than 85,000 migrant truck drivers, their spouses and families, cleaners and allied workers (workers in petrol pumps and roadside eateries; mechanics).

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## Reaching migrants at source, transit and destination points

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The South Asian Research and Development Initiative (SARDI), in partnership with the Center for People's Education (CPE) at Tirunelveli and NIRMAN at Mumbai, and with technical and financial support from FHI, implemented a source, transit and destination migration project called Aariyur, meaning Precious Lives. The Tirunelveli district in Tamil Nadu is drought prone and has high migration rates of young male migrants to cities such as Mumbai, mainly by the direct train, the Nagercoil Express. Approximately 300,000 migrants from Tirunelveli district live in Dharavi in Mumbai city, one of the largest slums in Asia. The Aariyur project was unique, representing a collaboration across states and with multiple agencies – its lessons indicated the need for comprehensive interlinked programs for source, transit and destination sites to best respond to the needs of migrants and their families at all stages of the migration cycle. Program experience indicated the need for extensive coordination from lead agencies, continuous capacity building of implementing organizations and technical support from donors, as migration and mobile populations require a holistic, multisectoral response to HIV/AIDS.

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interventions for HIV prevention and did not focus on building a response that went beyond service delivery to influence policy. Agencies such as the All India Motor Transport Congress Society (AIMTCS), a national-level organization working to protect the rights and interests of truckers, needed to do more by sharing its vision with member associations and allied corporate bodies to build corporate awareness and responsibility for the welfare of its employees.

FHI conducted a research study on migration in collaboration with NACO and the Indian Council for Medical Research. The study highlighted migration patterns (seasonality and geographic areas) and relative HIV risk factors. Based on the findings of this study, in 2002-2003, USAID/FHI began supporting two pioneering source and destination migration cross-border and interstate intervention projects in the states of Tamil Nadu, Andhra Pradesh and Maharashtra. By 2004-2005, USAID/FHI had scaled-up and was supporting eight migrant and workplace projects with 10 implementing partners to support evidence-based policies and programs on mobility, migration and HIV/AIDS risk in India.

The key strategic approaches in migration and workplace projects included:

- Partnering with national-level agencies working with mobile populations to ensure large-scale coverage of HIV prevention and care services for mobile populations and their families.
- Supporting source, transit and destination interventions and strengthening coordination mechanisms between partners to ensure comprehensive HIV prevention and care services for migrants and their families.
- Supporting SBC interventions to encourage adoption of safer sex practices and reduction of high-risk behaviors among the migrant communities at source, transit and destination sites, mobile populations and industrial workers.
- Improving access to STI care and VCT services at source and destination sites for migrants and their families, mobile populations and industrial workers.
- Providing care and support services for migrants and mobile populations and their families affected by HIV.
- Supporting sensitization and advocacy initiatives for creation of a supportive community response to ensure safe migration, provide comprehensive workplace intervention in both formal and informal sectors and influence policy.
- Building capacity of NGOs, networks and agencies such as AIMTCS in technical and program



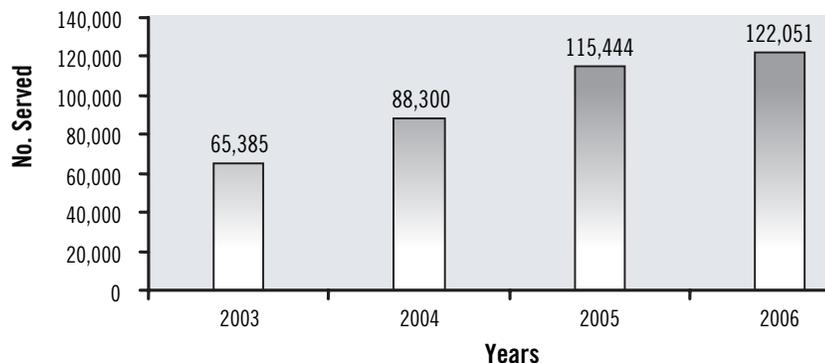
Twenty-nine-year-old Gowri, an HIV-positive widow, and her two children visit the mobile STI clinic in a slum area in Vijayawada town, Krishna district. Vijaya Nirmala, the project doctor, is examining Gowri. Supported by USAID/FHI, the project was a collaborative venture between All India Motor Transport Congress Society (AIMTCS) and a lorry owners association in Krishna district. Since September 2002, the project has provided comprehensive HIV prevention and care services to more than 85,000 migrant truckers, their spouses and families, cleaners and allied workers (workers at petrol pumps and roadside eateries; mechanics).

management areas of comprehensive HIV prevention-to-care for migrants, mobile populations and industrial workers.

FHI supported eight migrant, mobile population and workplace projects through 10 implementing partners, reaching a total of 391,180 migrants, truckers and their family members, as well as industrial workers, with HIV prevention messages. A total of 6,748 people were treated for STI and 447 PLHA were provided with care and support services. FHI supported the development of information, education and communication materials on STIs and HIV/AIDS for migrant populations to improve HIV prevention services. The growth in coverage of migrant populations under IMPACT is shown in Figure 7.

The findings of the national assessment on migration, mobility and HIV risk contributed to influencing national policy and programs with regard to interstate migrants. The USAID/FHI-supported migrant and workplace projects contributed to demonstrating best practices of source, transit and destination interventions that influenced the scale-up of similar interventions under NACP III. Further, FHI leveraged growing interest from other sponsors and mobilized additional funding of approximately £2 million from the Department for International Development (DFID) to support a three-year expansion of the cross-border source and destination project with Nepali migrants and their families in Nepal (source) and India (destination).

**Figure 7. Migrants, Truckers and Industrial Workers Reached Under IMPACT: 2003 – 2006**



#### **v) Comprehensive HIV Prevention-to-Care Projects in High HIV Prevalence Districts**

To support NACO's plans for decentralized district-level planning and mainstreaming of HIV activities within various government departments, FHI followed the Expanded Comprehensive Response (ECR) strategic framework to support the development of comprehensive district action plans for a multisectoral response to HIV. The focus of the district action plans was to expand program coverage to different population groups, improve the quality and scope of services and ensure the accountability of systems. FHI's efforts in comprehensive HIV care and support in high HIV prevalence districts required coordinating with a diverse range of stakeholders at different levels. This was a time-consuming process that required regular attention and negotiation.

In 2003, FHI initiated comprehensive HIV prevention-to-care projects in the high HIV prevalence districts of Namakkal and Tirunelveli in Tamil Nadu and Tuensang in Nagaland. The programmatic emphasis of these projects was on building an ECR through a coordinated effort with key stakeholders, including district administration and multisectoral involvement to ensure maximum impact at the district level. Unique was the Positive Living project implemented by a district level PLHA network, HIV Ullor Nala Sangam (HUNS), in Namakkal district in Tamil Nadu, where prevention and care activities were implemented in three Positive Living Centers and administered by trained PLHA. In addition, partners in Tirunelveli district were supported to implement a comprehensive prevention and care project to pilot community-based VCT in order to increase access to and acceptance of VCT services and to decrease stigma and discrimination.

The key strategic approaches in FHI's comprehensive HIV prevention-to-care projects included:

- Conducting situational assessments to provide strategic information for program planning and management.
- Building capacity of district administration and expanding partnerships for district-level strategic planning.
- Supporting ECR for HIV prevention, care and treatment through multisectoral district action planning.
- Supporting the implementation of comprehensive prevention-to-care projects with the key populations.

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#### **District action planning in Tamil Nadu**

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Based on FHI's Expanded Comprehensive Response (ECR) approach, technical assistance was extended to support government planning efforts in four high HIV prevalence districts of Tamil Nadu: Namakkal, Madurai, Theni and Tirunelveli. As part of this initiative, FHI supported the development and implementation of HIV/AIDS district action plans (DAPs) through a consultative process involving multiple stakeholders. The plans were integrated into the existing government district planning process to address HIV through a multisectoral response. FHI conducted comprehensive situational assessments at the district level to provide information on the current scenario and dynamics specifically in the context of the HIV epidemic in the district; specific needs of key population groups; current initiatives of different sectors and possible areas of integration of HIV services within existing programs; mapping of existing resources in the district; and gaps in responses to programming. The findings of the assessments were shared and discussed at a stakeholders' workshop in each district involved, including officials from the departments of health, rural development, education, women and child welfare, and transport; private doctors; and NGOs and CBOs working on health issues. The comprehensive planning process catalyzed stakeholders to initiate responses and created an environment in which previously uninvolved sectors began to respond to HIV issues within their respective areas of operation. The series of consultations with these stakeholders resulted in the development of comprehensive multisectoral DAPs.

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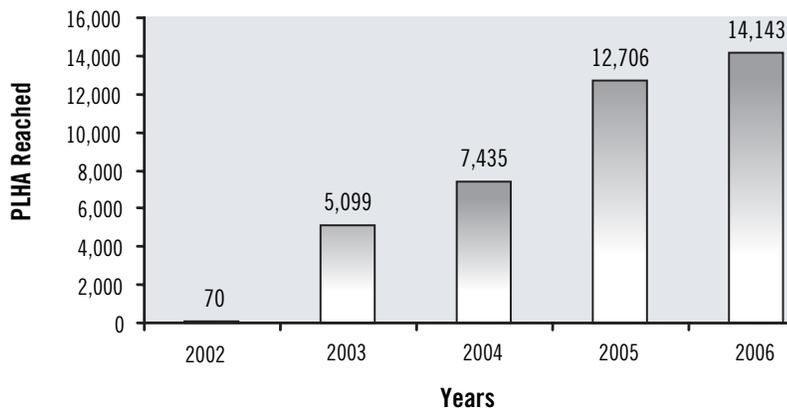


Twenty-three-year-old Lakshmi, a client of Paramthi Vellore Positive Living Center (PLC), is seen here with her two daughters. Lakshmi has benefited from the HIV prevention, care and support services of the PLC project. USAID/FHI supported the Indian Network for People Living with HIV/AIDS (INP+) through the district-level network partner HIV Ullor Nala Sangam (HUNS) to implement the project, which provides comprehensive HIV prevention, care and support services to PLHA in Namakkal district, Tamil Nadu.

- Strengthening capacity and involvement of PLHA networks in program planning and implementation to support GIPA.
- Mobilizing and strengthening capacity of local CBOs and FBOs and including religious, community and political leaders and self-help groups to provide community- and home-based care services for PLHA and their families, especially orphans and widows.
- Developing a network model involving government and civil society agencies to tap existing community resources for provision of comprehensive services for PLHA and their families, including schooling, clinical and palliative care, and socioeconomic and legal support services.
- Piloting innovative community-based counseling and testing model in rural settings to scale-up access to HIV testing in high HIV prevalence districts.
- Supporting advocacy initiatives for increased access to services including clinical, socioeconomic, household strengthening and legal support for PLHA and their families.

FHI supported five comprehensive HIV prevention-to-care projects with 19 implementing partners, including 13 state-level and district-level networks supported by the Indian Network for People Living with HIV/AIDS (INP+). These projects reached 14,143 PLHA and 391,049 other community members. The growth in the numbers of PLHA reached under IMPACT is shown in Figure 8.

**Figure 8. PLHA Reached Through Comprehensive Care and Support Projects Under IMPACT from 2002–2006**





Mariambevi, a community health worker, provides information on HIV/AIDS to members of a community self-help group and addresses HIV-related stigma and discrimination issues for increased social acceptance and community support for people living with HIV/AIDS. USAID/FHI has supported Peace Trust, an implementing NGO partner, to provide comprehensive HIV prevention, care and support to youth, children and families affected by HIV/AIDS in the rural communities of Tirunelveli district, Tamil Nadu, from September 2003 to 2006.

Recognizing FHI's experience in district action planning for comprehensive programming, NACO and SACS invited FHI to provide technical assistance in the development of NACP III as well as the state project implementation plan (PIP) in the states of Tamil Nadu, Andhra Pradesh and Maharashtra. The district action planning approach undertaken in Namakkal and Tirunelveli was subsequently scaled-up by the Tamil Nadu State AIDS Control Society (TANSACS) for all districts. Using HUNS as a network model, sponsors in other programs, including NACO, supported the replication of the Positive Living Center (PLC) approach for providing comprehensive HIV prevention, care and treatment services for PLHA and their families in other high prevalence districts. The community-based VCT model was replicated by TANSACS and AIDS Prevention and Control Project (APAC) for scaling-up VCT services in Tamil Nadu state.

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#### **Positive Living Project managed by district-level PLHA network in Namakkal, Tamil Nadu**

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FHI collaborated with the Indian Network for People Living with HIV/AIDS (INP+) to initiate a unique and comprehensive prevention-to-care Positive Living Project in Namakkal district in Tamil Nadu state. The project was implemented through HUNS, the district-level PLHA network in Namakkal. Three community-based Positive Living Centers (PLCs) were established at three sub-district headquarters, reaching 10,092 PLHA and affected family members through September 2006 via different services. The project had a strong focus on building referral linkages with the district health system for effective clinical services to OVC, PLHA and families. The project built the capacity of the network members, expanded outreach and encouraged a significant number of PLHA to access care and support services. The establishment of support centers met an important need for PLHA in terms of social space, support networks, medical services, and provision of information on treatment, care of children and other services. As one female support group member living with HIV/AIDS said, "The support group meetings have given us mental stamina, provided those of us with children and no means the ability to provide education and food and access to ART." This project is an excellent example of putting the concepts of GIPA into practice. INP+ is replicating this model in other parts of the country.

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#### **An Anganwadi Worker Tale...**

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Muthamma has been an *anganwadi* worker (a village-level worker under the government's Integrated Child Development Scheme) since 1991. When the staff of the Preeyam Nesam project in Tirunelveli district in Tamil Nadu came to the village asking if she would be interested in being a community caregiver, she readily agreed. She had seen a few men in the village die of HIV/AIDS and empathized with their widows. "The staff trained us very well and I am proud of doing service to my community in addition to my work of taking care of the children in the *balwadi* (children's day-care center). I now have a kit and medicines and people call me a "doctor amma" I also teach people that those with HIV/AIDS should not be ostracized because AIDS cannot spread by touch and casual contact. More people are beginning to listen to me. We go every month to the project center to fill our kits and have meetings. I have learned a lot."

### vi) HIV Care and Support Projects for PLHA, Including GIPA

Globally, it is recognized that an effective response to the HIV epidemic requires effective partnership and the active involvement of PLHA at every level. One of the major factors that hinder meaningful involvement is that PLHA and their organizations do not have the skills, experience and capacity to effectively participate in policy dialogue and program development. It is important to provide support to PLHA and community-based PLHA organizations to build their capacity for meaningful involvement at all levels. Since 1997, FHI has partnered with INP+ and affiliated state and district networks to build organizational and management capacities including securing Secretariat and governance support, strengthening organizational systems and structures, and building leadership and program management capacities. In addition to capacity building of INP+, FHI supported a total of 13 state-level networks, four district-level networks and the Positive Women's Network (PWN+) for organizational development.

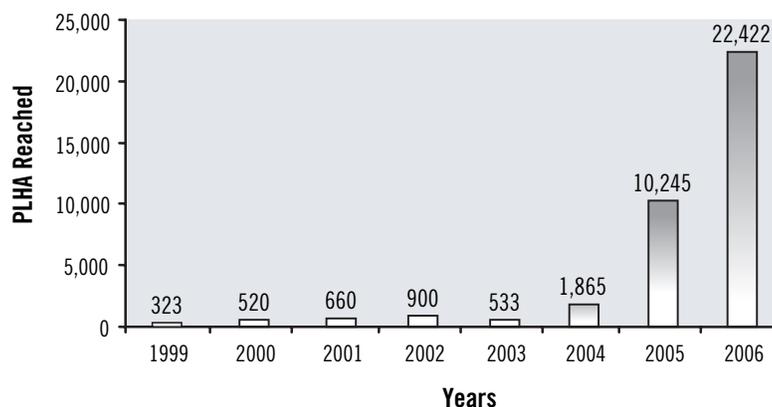
The key strategic approaches under the HIV care and support projects included:

- Supporting innovative demonstration projects on home-based care in low HIV prevalence settings.
- Providing community- and home-based care services for female sex workers and their clients.
- Strengthening the institutional capacity of INP+, a national-level PLHA network for GIPA and advocacy on PLHA issues at the national, state and district levels.

FHI supported five projects addressing HIV care and support and GIPA with seven implementing partners, reaching 22,422 PLHA and 29,415 community members. The growth in numbers of PLHA reached by care and support projects under IMPACT is shown in Figure 9.

In 2001, FHI supported a pilot home- and community-based care and support project for PLHA in a low prevalence setting. Project strategies included strengthening linkages with centers where people are tested, diagnosed and treated for HIV and other health problems; increasing PLHA access to home-based care services; strengthening capacity of caregivers and family members to provide care for PLHA; and strengthening project management through capacity building of staff and strengthening of systems.

**Figure 9. PLHA Reached Through Care and Support Project Under IMPACT 1999–2006**



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## Providing HIV care and support services in a low prevalence setting

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The sentinel surveillance data in 2001 showed that HIV prevalence in STI clinics in Delhi was about 4.6 percent. Delhi is categorized as one of India's low prevalence states, but it is vulnerable due to the presence of migrants, underprivileged and high-risk groups such as street and working children, drug users, sex workers and men who have sex with men. Naz Foundation (India) Trust is an organization based in Delhi working on issues of sexuality, HIV/AIDS, sexual minorities and capacity building of NGOs. Since October 2001, FHI has supported Naz Foundation to implement a community-based care and support project for PLHA. Initially, the primary goal of the project was to "empower people with HIV/AIDS and enable them to cope and manage their infection by providing care, knowledge, skills and support." Following review assessments, the project adapted a new strategy, which included reaching out to HIV testing sites in Delhi to refer PLHA to a home-based care program. To reduce the socioeconomic impact of HIV, the project shifted from a biomedical model to a social support model.

The social support model adopted by Naz Foundation resulted in increased acceptance of the community and home-based care program. To provide a wide range of services, the program networked with various agencies and services including food, economic and legal support. Through this approach, the project was able to provide a range of support based on the needs of clients and enhanced PLHA knowledge and understanding in several areas, including care and treatment and ART compliance. Linkages with testing sites resulted in increased numbers of PLHA and caregivers participating in the project, which demonstrated that linking with testing sites is a suitable strategy to introduce PLHA to early care and support services in a low prevalence urban setting. This was an innovative public and private partnership model for HIV/AIDS care and support. The project reached a total of 360 PLHA and 106 OVC in 244 households.

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In 2004, as support to PSI's USAID-funded Operation Lighthouse project in Mumbai, FHI supported two community- and home-based care projects for female sex workers and male PLHA and their families. The projects aimed at bridging the gap between diagnosis and care for female sex workers and male clients living with HIV, along with promoting prevention in care settings. These projects adopted community-based and peer-led approaches to extend care and support services and promote risk reduction through SBC.

The institutional strengthening of INP+ under IMPACT has provided INP+ with the platform to expand its network building activities and advocate for PLHA issues at the national, state and district levels and has resulted in the leveraging of funds from several other sponsors. Through 2006-2007, INP+ managed a portfolio of 29 projects (including small grants) supported by nearly 26 sponsors. INP+'s annual budget for financial year 2006-2007 was approximately US\$2.5 million. INP+ is the largest PLHA CBO in India,

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## Promoting GIPA at all levels ...

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FHI operationalized the concept of GIPA in all of its intervention projects by partnering with INP+:

- i) **Capacity Building of IMPACT Implementing Partners:** INP+ provided technical assistance to operationalize the principles of GIPA in all IMPACT-supported projects. INP+ organized regional orientation workshops for partners on GIPA principles including capacity/skills building of PLHA; meaningful employment of PLHA in projects; participation of PLHA in project design, implementation and monitoring; and participation of PLHA in sensitization and advocacy programs.
  - ii) **National Consultative Group on GIPA:** FHI was instrumental in supporting INP+ to form and lead a Consultative Group on GIPA with the involvement of NACO, UNAIDS, United Nations Development Programme (UNDP), CDC, state networks of PLHA and other donors to contribute to national policy and coordinate efforts on GIPA.
  - iii) **National GIPA Strategy:** FHI supported a national workshop on GIPA to frame specific strategies for operationalizing GIPA at individual, community, NGO, donor and government levels. INP+ developed a GIPA strategy paper on levels and types of involvement of PLHA in the response to HIV/AIDS in India, which was adopted by NACO under the national program.
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Megha, a health worker with the Roshni project, orients a group of female sex workers (FSWs) about reproductive health using a female reproductive organ model during a health education session at the Roshni project drop-in center. The project was implemented by Committed Communities Development Trust (CCDT). Beginning in 2004, with funding from USAID, FHI supported the Roshni project to provide HIV prevention, care and support services to FSW in Kamathipura, a red-light area in Mumbai.

implementing the largest number of projects and managing funds to address network building, advocacy, and service delivery for, of and by PLHA. INP+ and FHI were invited to participate in the working group created by NACO to draft recommendations and strategies on GIPA and legal and ethical issues in the design of the NACP III.

## **B. Technical Assistance (TA) and Capacity Building**

TA has been a major area of need in India. FHI has provided TA to the Government of India, NACO, SACS and USAID-supported bilateral agencies (APAC and Avert) and has strengthened the quality of its own interventions through TA and capacity building by introducing guidelines for quality assurance (QA) and quality improvement (QI). (TA to implementing partners is addressed in this report in section IV A. on Demonstration Projects.) The major areas of technical assistance are listed below and include formative assessments, technical studies, capacity building in program management and technical areas including operationalization of the O/GAC guidelines on ABC; Computerized Management Information System (CMIS); and operationalization of the three cross-cutting themes: gender, GIPA, and reducing stigma and discrimination.

The stakeholders and key areas of FHI technical assistance under the IMPACT project in India included:

- i. Technical Assistance to NACO, SACS and Government of India
  - Drug user studies
  - Migration study
  - GFATM proposals
  - Surveillance
  - NACP III design, state PIP, district action planning
- ii. Technical Assistance to USAID Bilateral Partners (APAC and Avert) and Other United States Government Partners
  - Program management, research and technical areas in HIV prevention, care and support

iii. Technical Assistance to Implementing Partners Including NGOs, CBOs, FBOs and PLHA Networks

- Operationalization of O/GAC guidelines on ABC approach
- Operationalization of cross-cutting themes (gender, GIPA, and reducing stigma and discrimination)
- Organizational development and systems strengthening
- M&E including design and management of project-level CMIS and integration of PEPFAR indicators

i) TA to NACO, SACS and Government of India

- USAID/FHI assisted NACO in developing project proposals for several rounds of submission to GFATM over five years (2002–2006). During this time, India was awarded grants by GFATM worth US\$195,933,236 for HIV prevention, PPTCT, ART, tuberculosis-HIV co-infection, and care and support.
- FHI collaborated with NACO and the Indian Council of Medical Research (ICMR) to conduct two assessments on drug user and HIV risk. These included:
  - *NACO/ICMR/FHI Collaborative Study on Differentials in the HIV Epidemic Amongst Drug Users in the Northeast States*: This study was undertaken to gain understanding of the reasons for the differences in HIV prevalence among drug users in five of India's Northeast states: Assam, Manipur, Meghalaya, Mizoram and Nagaland. In addition, an assessment was conducted involving a literature review and key informant interviews in these states. A stakeholders' workshop was conducted with 45 participants from the five Northeast states to validate findings of the assessment and recommend future steps. The most significant assessment finding was the lack of sufficient scientific data to explain the differences in HIV prevalence among drug users in these states. There were no studies on size estimates of drug user populations in the different states, their injection and sexual risk behavior patterns or other epidemiological, social and anthropological factors contributing to the spread of HIV among



Joy Chandra counsels Bijoy Halder, who is HIV-positive. Joy Chandra is a social worker with Social Awareness Service Organization (SASO), an NGO working with drug users and people living with HIV/AIDS in Imphal, Manipur state. From July 2003 to September 2006, USAID/FHI provided grant management and financial assistance to SASO to provide care and support services to drug users and people living with HIV.

this population. The assessment report was finalized and presented to a Technical Steering Committee, which recommended that drug user size estimation activities be initiated in the five Northeast states.

- *NACO/ICMR/FHI Collaborative Study on Mapping and Size Estimation of Drug User in Five Northeast States of India:* This study was coordinated by the Regional Medical Research Center (RMRC), an ICMR institute based in Assam. Local partners were identified in each of the five Northeast states through an organizational assessment. The fieldwork for mapping and size estimation was completed and the data were analyzed in a regional workshop. Findings from the mapping and size estimation study were useful for planning effective interventions for drug users and provided necessary information to develop a sampling frame for future behavior and biological surveillance surveys among drug users.
- *NACO/Ministry of Social Justice and Empowerment (MOSJE) Collaborative Rapid Assessment:* NACO invited FHI to conduct a rapid assessment of their ongoing collaborative project for integrating HIV/AIDS into drug treatment programs funded by the MOSJE to identify lessons learned. A team of FHI consultants interviewed key stakeholders and visited 25 randomly selected addiction treatment centers in different regions of the country to meet with staff, clients in treatment and community members. The design of the rapid assessment focused on the review of the integration process as well as identification of lessons learned using mostly qualitative tools (including in-depth interviews, focus group discussions and observations).

Assessment findings recommended continuation of this unique collaborative project within the framework of an expanded NACP III, while strengthening certain program areas, improving the quality of services and expanding the intervention. Based on the recommendations of the report, the MOSJE along with the United Nations Office of Drugs and Crime (UNODC), held a workshop for all stakeholders to develop an action plan to integrate HIV/AIDS issues into all existing drug treatment programs. The NACP III design team used the report as an example of inter-ministerial linkages and mainstreaming of HIV/AIDS in different government sectors to strengthen and expand the existing program.

- *Department of Family Welfare/NACO/FHI Collaborative Assessment of PPTCT Program in India:* In 2004-2005, USAID/FHI provided technical assistance to the Department of Family Welfare, GOI and NACO in carrying out a rapid assessment to help determine the desirability of expanding the PPTCT program from the district hospitals to the sub-district-level health facilities—that is, the community health centers (CHC), primary health centers (PHC) and sub-centers. The assessment was conducted in four districts in four regions of India through consultative meetings with key national- and state-level stakeholders; appraisal of the PPTCT services at the district level; observation and participatory discussion to gain understanding of the infrastructure and human resources available at the various levels; and participatory discussions with the community, family members and traditional birth attendants on their roles and attitudes toward the PPTCT services.

The major study findings were that the PPTCT program had varying performance levels in the four states under study. There was an overall willingness among the sub-district health staff to undertake the PPTCT program but they had received limited orientation and information on the program. The study recommended that the various components of the PPTCT program be implemented at the PHC level by building the capacity of the staff and strengthening the existing infrastructure. Innovative strategies were explored for participation of the private sector in the PPTCT program implementation. The recommendations of the assessment were used to inform the expansion of PPTCT services to the sub-district level under the National Reproductive and Child Health Program and NACP III.

- *NACO/ICMR/FHI Collaborative Assessment of Mobility, Migration and HIV/AIDS Risk in India:* In 2003-2004, NACO, FHI and USAID initiated an assessment to gain understanding of mobility and migration and HIV/AIDS risk in India. The objective of the assessment was to describe the typology of migration that delineates various types of mobility and migration and describe the associated HIV/AIDS risk factors that promote vulnerability to HIV/AIDS within each type. The study was carried out in two phases. Phase 1 included review of existing literature; interviews with key experts in the field of mobility and migration; and regional consultations with representatives from NGOs working with mobile and migrant populations. Phase 2 used an ethnographic approach and employed qualitative tools such as focus group discussions, in-depth interviews, key informant interviews, route mapping and lifeline exercises.

The major findings of the assessment were: i) not all mobile and migrant groups were at risk of HIV by virtue of being mobile and/or migrant; it was the setting they placed themselves in and an interplay of factors (individuals and/or settings) that determined their vulnerability or risk; and ii) pre-mobility characteristics such as literacy level, marital status, economic opportunities and other characteristics continued to influence the post-mobility phase and determined an individual's access to information, services and basic rights at the destination, which further contributed as vulnerability-enhancing and/or vulnerability-reducing factors.

The assessment findings underscored the need to develop interventions and design programs for source locations to prepare mobile and migrant groups to face the new social environment, specifically highlighting linkages of risk behavior, self-risk perception and HIV infection. The primary factors that determined vulnerability were sexual permissiveness (linked with the anonymity that the new social environment offers); lack of social support, i.e., a feeling of belonging to a group and/or setting; access to institutional arrangements; and condom availability and access in new settings. The study emphasized the need for strengthening HIV interventions linked to mobility and migration; implementing interventions designed to operate at source, transit and destination; and coordinating mechanisms within and between states, for which NACO and SACS could play an important role.

- *Technical assistance to SACS:* Areas of TA included district action planning for Namakkal and Tirunelveli districts; development of care and support strategy; VCT scale-up; development of an M&E framework; and integration of HIV/AIDS and reproductive and child health programs.

While concentrating on the high HIV prevalence districts of Namakkal and Tirunelveli, FHI collaborated with the Futures Group to develop district plans for all 30 districts of Tamil Nadu to inform the development of a comprehensive state HIV/AIDS PIP. FHI provided TA on the district-level situation assessments in the districts of Namakkal, Tirunelveli, Madurai and Theni and provided TA to the SACS in the states of Andhra Pradesh and Maharashtra. FHI also participated in the working groups, consultative meetings and project implementation planning process.

- In 2005, USAID requested FHI to provide technical assistance in the design and planning process for GOI's NACP III for the period 2006–2011. FHI was part of two working groups focusing on a) women, youth and children and b) PLHA, GIPA, legal issues and human rights. FHI provided technical assistance by participating in these working groups and providing recommendations for the NACP III strategy document. FHI also participated in the NACP III Draft Strategy Consultative meetings and provided major inputs on OVC programming in India. Under NACP II, OVC had not been included as a target group. FHI partner agencies working on OVC issues participated in the regional NACP III planning consultations. Through its collaborative studies on migration with NACO, FHI was able to discuss the risk factors especially common among migrant populations and influenced thinking on cross-border interventions for NACP III, which had not been previously undertaken by NACO and the SACS. Until recently, the focus had been primarily on migration within states.
- FHI provided technical assistance in the planning phase of the Phase II National BSS.
- In collaboration with the Program for Appropriate Technology in Health (PATH) and NACO, FHI developed a BCC strategy for addressing stigma and discrimination. A BCC strategy was developed for Namakkal district as technical assistance to the District Collector, as part of the district action planning.
- USAID requested FHI to provide technical assistance in the design and planning of the National Family Health Survey (NFHS). NFHS-3 is the third round of the large-scale, multi-round survey conducted in a representative sample of households throughout India. The survey provides national and state information for India on fertility, infant and child mortality, family planning, maternal and child health, reproductive health, nutrition, anemia, and the use and quality of health and family-planning services. This is the first time that HIV testing and a behavioral questionnaire including knowledge, behavior and attitude questions on sexuality, HIV/AIDS and STIs have been included in the household survey. FHI provided technical assistance in three areas: i) questionnaire development; ii) sampling procedures and data collection for geographic representation; and iii) ethical issues related to HIV testing. It was the first time that the survey included information from the six high HIV prevalence states in India.
- FHI became a member of the OVC Task Force led by the GOI's Department of Women and Child Development. The task force held regular meetings, and FHI provided inputs and shared experiences from its partner projects.



Sister Chaitanya counsels a client, Kasturi, while the community nurse, Sharada, takes a blood sample and stores it appropriately in a vaccine box. USAID/FHI has supported Arumbugal Trust, Aussi-CODES, Peace Trust and the Center for People's Education to provide comprehensive HIV prevention, care and support services to youth, children and families affected by HIV and AIDS (September 2003 to 2006) in Tirunelveli district, Tamil Nadu.

### **ii) TA to USAID Bilateral Partners and Other USG Partners**

FHI provided technical assistance to the two USAID-supported bilateral agencies, APAC (Tamil Nadu) and Avert (Maharashtra) in the following areas:

- Five start-up studies (Avert)
- BSS: design, implementation and analysis of two rounds of national BSS and two rounds of BSS (Avert)
- Care and support strategy for Tamil Nadu State AIDS Control Society (TANSACS)
- VCT scale-up strategy (APAC and Avert)
- Communication strategy (APAC)
- Condom strategy (APAC)
- STI strategy (APAC)
- Operationalization of O/GAC guidance on ABC approach to HIV prevention
- MIS: integration of PEPFAR indicators into existing reporting
- Workplace intervention and action strategy (Avert)
- Management system assessment and technical assistance (Avert)

FHI also conducted training programs for the staff of USG partner agencies in India—CARE India, PSI, Futures Group (POLICY Project) and others—on technical HIV/AIDS issues, operationalizing, ABC guidelines and program management.

### **iii) TA to Implementing Partners**

FHI provided initial technical assistance to partner agencies in project development strategies and approaches, defining appropriate indicators, developing systems for monitoring and program management, including MIS and financial management systems, and sustainability. FHI's ongoing technical assistance included various technical updates on HIV prevention and care, SBC, LSE, counseling, treatment, networking and advocacy, PPTCT and QA/QI. All partners were trained on the three cross-cutting themes: GIPA, gender, and reducing stigma and discrimination. Technical support was also provided in the development of SBC material for different target populations, especially OVC, MSM, drug users and migrants. FHI provided technical support in the development of various assessments, research studies, SBC and advocacy strategies and technical documents. A detailed list of materials and

## QA mechanism being developed at a community VCT center in Tamil Nadu

As part of a comprehensive HIV prevention and care project in a high prevalence district, Tirunelveli in Tamil Nadu, a community-based VCT center was set-up where community mobilization activities increased risk perception among community members. FHI was instrumental in conceptualizing this approach as part of its continuum-of-care intervention. FHI drafted the SOP (Standard Operating Procedures) for VCT in participation with partner agencies. This was a pioneering initiative that has emerged as a model approach to HIV testing for the state of Tamil Nadu. Risk assessment and pre-test counseling occurs in community settings (home or clinic), and a project nurse draws blood, which is transported to the private hospital for HIV testing. The test reports are sent back to the project counselor in a sealed envelope. Post-test counseling is provided to all clients, and ongoing counseling and care and support services are provided to clients who test HIV-positive. An external QA mechanism is in place to ensure the quality of HIV kits used. A qualitative assessment has shown the increase in the uptake of VCT services in the district.

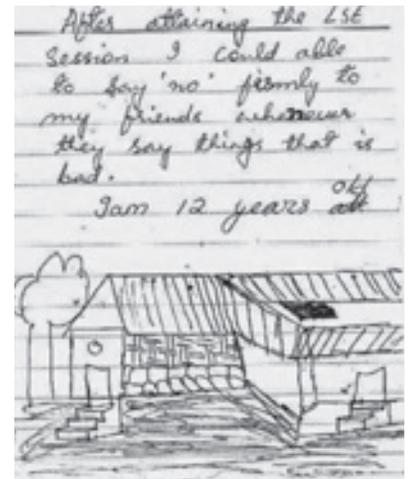
technical documents produced by FHI and its partner agencies is given under section VII B. (Attachments). FHI has also provided ongoing support during regular monitoring visits and during the mid-term and end-term reviews.

## Key Areas of Technical Assistance

### Operationalizing O/GAC Guidelines on ABC Approach

USAID/FHI introduced the ABC approach into program strategies in mid-2005. The plan for operationalizing the ABC approach included orienting implementing partners on the O/GAC guidelines through regional workshops. Using a participatory approach, partner projects' specific communication strategies, BCC materials and condom programming were reviewed and specific action plans were developed for strengthening ABC implementation. Following this orientation workshop, FHI provided support to partners in implementing their action plans. At USAID's request, FHI provided technical assistance to other USG HIV/AIDS programs including APAC (Tamil Nadu) and Avert (Maharashtra) to help them integrate the ABC approach into their programs. A participatory workshop was held to discuss the ABC guidelines; Avert was further assisted in developing an ABC action plan for all of its projects in Maharashtra.

In February 2006, after six months of ABC work, partner organizations came together to share experiences in operationalizing the ABC approach. Partners believed that the ABC approach could be promoted and they had found creative ways of dealing with challenges. LSE was discovered to be a useful tool for developing AB skills in children. A number of case studies reported unmarried individuals moving to abstinence from a sexually active life; some NGOs reported an increase in condom use by youth older than 15 years (after the message of correct and consistent condom use was promoted), along with A and B.



### Child-Centered Technical Resources for OVC

Through its work in India, FHI realized that there was a lack of child-centered HIV/AIDS materials and tools in India. As a result, FHI developed the following technical resources:

- i) Life skills education (LSE) toolkit for OVC in India
- ii) Protocol for child counseling on HIV testing, disclosure and support
- iii) Protocol for detoxification and rehabilitation for substance-using children
- iv) Child- and youth-friendly communication materials to promote HIV prevention



Adolescent girls are involved in a participatory activity as part of the life skills education (LSE) sessions conducted at the Young Women's Christian Association (YWCA). This session, called "Double Wheel," helps to develop self-awareness and communication skills among adolescents and children. The sessions are adapted from the LSE toolkit developed by FHI under the IMPACT project.

### **Life Skills Education (LSE) Toolkit**

The LSE toolkit deals with the "whole child," his/her feelings, beliefs and needs as he/she grows up, as well as the life skills associated with making safe choices and maintaining healthy lifestyles. The toolkit aims to help children develop skills to prevent STI/HIV infection, to manage and cope with risky life situations related to HIV/AIDS and to cope with difficult circumstances related to care and support. The kit consists of 10 modules and includes participatory approaches; children use the 3P matrix of problem identification, problem prioritization and problem analysis.

The toolkit was developed through a participatory process and took more than two years to create. This process included involvement of several partner agencies across the country in regional workshops and field-testing. The toolkit was reviewed nationally and internationally and the process included extensive sharing of experiences and feedback. The kit was developed to be relevant for the Indian cultural context, and a variety of programs for children from diverse settings were involved in the field-testing. These included programs in shelter homes, on the street, in communities, and in urban and rural red-light areas. Girls and boys ranging from 6 to 18 years were also involved in developing the toolkit. Some were living with parents with HIV or orphaned by AIDS, some were children of sex workers, and others were from marginalized communities or migrant populations. The toolkit was field-tested in the project areas of FHI's implementing partners in 17 locations with more than 750 children across six states. The HIV prevention messages in the toolkit comply with the O/GAC guidance on ABC.

As part of LSE, weekly sessions were organized with groups of children and included an interactive activity followed by a group discussion and tips for "linking learning with life." These lively discussions helped the children to internalize and practice the skills in real life settings. The manual is not prescriptive and suggests that facilitators adopt a "cafeteria-like" approach by choosing those sessions that they feel are most appropriate for their group of children. Life skills empower children, and the active learning methods ensure that children enjoy themselves while they learn to lead safe, healthy and happy lives. FHI's partner agencies have used the toolkit for more than two years. Given its popularity, the toolkit has been

published in English and translated into other local languages: Hindi, Marathi, Tamil and Telugu.

### **Protocol for Child Counseling for HIV Testing, Disclosure and Support**

Recognizing the need for locally relevant materials addressing OVC psychosocial support in India, FHI, through the South India AIDS Action Program, began developing a counseling protocol for children vulnerable to, affected by and living with HIV/AIDS. The protocol followed a participatory process that involved consultation with psychologists, psychiatrists, sociologists and staff in partner agencies working with children. It was reviewed extensively in India and internationally by child specialists and NGO practitioners and was field-tested with a large number of children in different settings. The protocol follows a holistic approach to counseling, considering HIV/AIDS as one among many issues in a child's life.

The protocol provides guidance to counselors on taking into account the age of the child, the child's counseling need and the circumstances. It also discusses ethical dilemmas that a counselor may face in dealing with children living with and affected by HIV/AIDS and provides guidance to program managers and counselors about consent procedures, support systems for counseling, and quality of counseling services. The guidance on HIV testing has been developed for counselors working both within and outside of a HIV counseling and testing center. The protocol has been printed in English and translated into local languages Hindi, Marathi, Tamil and Telugu. Counselors working in a variety of OVC partner projects in India have been trained to use the protocol.

### **Child-Friendly Communication Materials**

FHI facilitated the development of two sets of communication materials for children: i) flash cards and a board game for vulnerable and at-risk children and ii) a flip book and flash cards for children infected with and affected by HIV. The materials were developed through a participatory and consultative process. The HIV prevention messages in the materials comply with the O/GAC guidance on ABC and address the routes of HIV transmission; stigma and discrimination; HIV care and support requirements of children; and coping with risky situations. These communication materials have been used by NGO staff and field workers, partner agencies and other development sector agencies working with children and adolescents, both girls and boys under 18 years of age. The materials were produced in English and Hindi and translated into other Indian regional languages such as Tamil, Telugu and Marathi. NGOs and communities have found these materials to be useful tools in promoting messages for HIV prevention and care.

### **Child Detoxification and Rehabilitation Protocol**

In India, protocols existed on adult detoxification and rehabilitation but no protocol was available on detoxification and rehabilitation of children. FHI, along with two NGO partners working with substance-using children, compiled the Child Detoxification and Rehabilitation Protocol by gathering information on existing systems and procedures. The document includes information on clinical detoxification, the process of registration, consent procedures, therapeutic regimes, medical and nursing needs, counseling and other psychosocial supports provided at the



Shazda rummages through items she has collected so that she can sell them. She works in the early morning hours and attends vocational training activities in the afternoons at the Young Women's Christian Association (YWCA) of Delhi Family Service Center in Najafgarh, located on the outskirts of west Delhi. USAID/FHI supported the YWCA of Delhi to reduce the vulnerability of street and working children in the urban slums of the Najafgarh area from September 2002 to September 2006.

residential facility, and the follow-up and referral mechanism. This protocol can be used by any organization working with or interested in working with substance-using children.

### **Computerized Management of Information Systems (CMIS)**

FHI designed a CMIS to facilitate simplified data entry by partners, data compilation, data analysis and reporting. To ensure compatibility with NACO's existing CMIS, FHI reviewed NACO's reporting system to develop a compatible indicator list. FHI categorized project-level monitoring indicators into thematic program areas aligned with NACP II. The CMIS has both automatic and dynamic reporting features to provide analysis to partners, donors and NACO as required.

### **Integration of Cross-Cutting Themes**

The following three cross-cutting themes were integrated in all IMPACT work in India: GIPA, gender, and reducing stigma and discrimination. FHI supported the capacity building of INP+, the largest PLHA network in the country. Under IMPACT, INP+ developed a GIPA strategy through a consultative process that was adapted by NACO under the national program. The concept of GIPA was made operational by ensuring capacity building of PLHA networks, meaningful employment of PLHA in projects in various capacities, participation of PLHA in the design, implementation and monitoring of projects, and involvement of PLHA in sensitization and advocacy programs.

Gender was addressed through skill building and participation of girls and women in program design, implementation and evaluation, organizing women into self-help groups and ensuring that all projects offered gender-sensitive services. Male involvement within HIV prevention, care and support interventions was emphasized, including referral for treatment of both partners for STIs, partner counseling on STI/HIV, condom promotion to both partners, and improved negotiation skills and communication between partners on consistent condom usage. The needs of transgender communities, including hijras, were addressed through comprehensive interventions, and their active participation was encouraged in the design, implementation and evaluation of transgender/hijra projects. Intervention projects were designed to address stigma and discrimination at all levels. Counseling and psychosocial support for PLHA focused on addressing self-stigma, counseling of family members and caregivers and ensuring protection of basic rights. Sensitization of community,

religious and political leaders, training and sensitization of healthcare providers, and sensitization of management and workers in workplace intervention projects were undertaken to protect the rights of PLHA. Redressal mechanisms including legal assistance were integrated into projects to prevent discrimination against PLHA and address double discrimination of marginalized populations.

### **Participation in International and National Conferences**

FHI supported the participation of officials from the government (NACO and SACS), USAID bilateral partners and implementing partner staff in international and national workshops and conferences on HIV/AIDS, surveillance and size estimation. Several IMPACT-supported implementing partners were invited for plenary sessions and poster presentations during conferences where project experiences were shared and best practices and lessons learned from the projects were presented.

## **C. Program Results**

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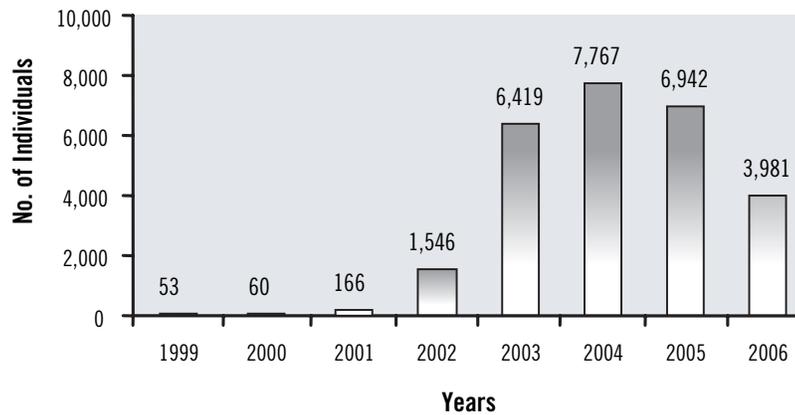
### **i) Program Outputs**

Some of the key program outputs achieved by FHI from 1999 to 2006 are listed below:

- Ninety-three implementing partners supported for 63 projects on OVC, drug users, MSM, migrants, PLHA and FSWs in six states and one union territory.
- Technical assistance in research, program management and technical areas provided to 40 collaborating and technical assistance partners.
- Capacity of 26,934 individuals developed in program management and technical areas through trainings, on-site support, mentoring and technical assistance. A summary of the number of individuals trained under IMPACT is shown in Figure 10.
- Sixty-three end-of-project reviews undertaken adopting participatory methodologies.
- District-level multisectoral action plans developed for four districts of Tamil Nadu state.
- Comprehensive situational assessment and mapping undertaken in four districts in Tamil Nadu and one district in Nagaland.
- Positive Living Center (PLC) and community-based VCT models piloted in Namakkal and Tirunelveli districts of Tamil Nadu.
- Four child-centered technical resource materials for children produced in English and translated into four local languages—Hindi, Marathi, Telugu and Tamil:
  - Life skills education (LSE) toolkit
  - Protocol for counseling, testing and disclosure of HIV status for children
  - Protocol for detoxification and rehabilitation for substance-using children
  - Child- and youth-friendly communication materials to promote HIV prevention
- BCC strategy to address stigma and discrimination developed.
- Mapping and size estimation study of drug users and partners in five Northeast states completed.
- Qualitative study on migration, mobility and HIV risk in India undertaken at 13 sites.
- Exploratory assessment for expansion of PPTCT services to the community health centers and primary health centers undertaken.

A detailed list of the materials produced by FHI and its implementing partners is provided as Attachment VII B.

**Figure 10. Individuals Trained Under IMPACT: 1999–2006**



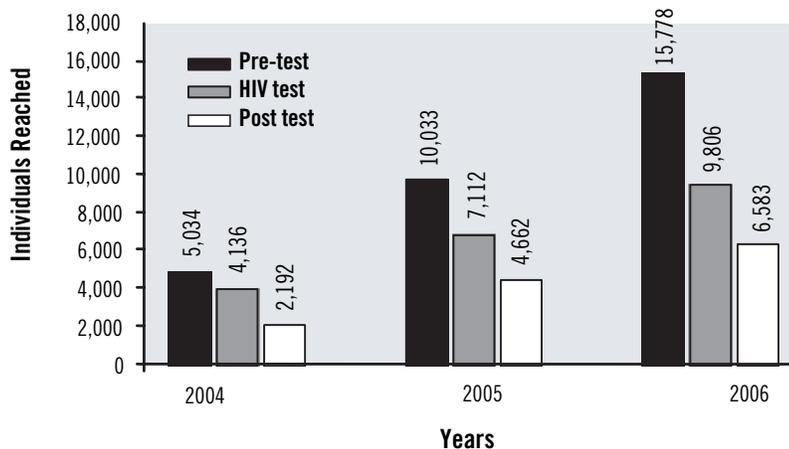
*Service Outputs*

The outputs noted below consist of services provided to clients reached by FHI subagreement awardees for the period 1999–2006.

- Total number of direct beneficiaries reached – 1,607,571
- Number of OVC reached – 49,455
- Number of PLHA reached – 41,560
- Number of MSM reached – 36,998
- Number of community members reached – 1,070,459
- Number of migrants and truckers reached – 391,180
- Number of drug users reached – 17,919
- Number of persons receiving counseling and testing services – 30,845<sup>10</sup>
- Number of STI cases managed – 33,631<sup>11</sup>

A summary of the increase in the number of people reached through counseling and testing services is shown in Figure 11.

**Figure 11. Number of Individuals Reached Through Counseling and Testing Services: 2004–2006**



<sup>10</sup> Counseling data available only for 2004–2006.

<sup>11</sup> STI data available only for 2004–2006.

## ii) Program Outcomes

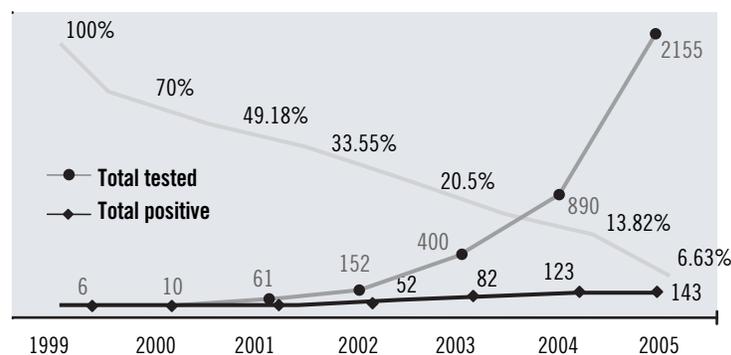
FHI assessed the outcome of its India program through select outcome assessments in different program areas. Five outcome assessments were undertaken in 2006 and included: one OVC project (St. Paul’s Trust); one MSM project (The Humsafar Trust); one migration project (SARDI); and two comprehensive HIV prevention-to-care projects (ECS and Peace Trust–Arumbugal Trust). In addition, FHI conducted an outcome assessment of the LSE component within OVC projects to assess the qualitative and quantitative outcomes of integrating LSE within the ongoing OVC interventions. This section presents the key findings from two intervention project assessments, one with drug users and the second with the MSM and transgenders and the LSE outcome assessment.

### Outcome Assessment of Comprehensive HIV Prevention-to-Care Project with Drug Users in Tuensang District, Nagaland

An outcome assessment of the comprehensive HIV prevention-to-care project with drug users implemented by Eleutheros Christian Society (ECS) in Tuensang district of Nagaland was undertaken by FHI through an independent consultant. The key findings of the assessment are highlighted:

- The project was able to demonstrate a “decentralized community owned care and support model.”
- ECS’s ongoing and effective advocacy led to a breakthrough—the involvement of the Churches Alliance representing the major five tribal churches. With technical assistance from ECS, the churches initiated their involvement in HIV care and support activities by providing counseling services to PLHA and involving them as peer educators. With strengthened capacity, the churches received funding from the Nagaland State AIDS Control Society (NSACS) to scale-up their HIV/AIDS care and support interventions. Continuous technical support as well as some of the elements included under USAID/IMPACT funding, such as nutritional supplementation to PLHA, travel assistance for CD4/CD8 counts, LSE, and support to OVC, were implemented through the churches. Interaction with the church leaders during the assessment revealed their clarity in implementing these activities.
- ECS actively advocated with the Tribal Councils (large CBOs) for supporting HIV prevention, care and support initiatives in the region. This resulted in one of the Tribal Councils of

**Figure 12. HIV Testing in Tuensang since 1999**



Noklak town becoming a partner of ECS. This Tribal Council agreed to undertake an HIV prevention project with technical assistance from ECS. The involvement of Tribal Councils in HIV prevention expanded the scope of efforts to address the HIV epidemic, improved the acceptance of PLHA in the community and helped in reduction of stigma and discrimination in their respective tribal communities.

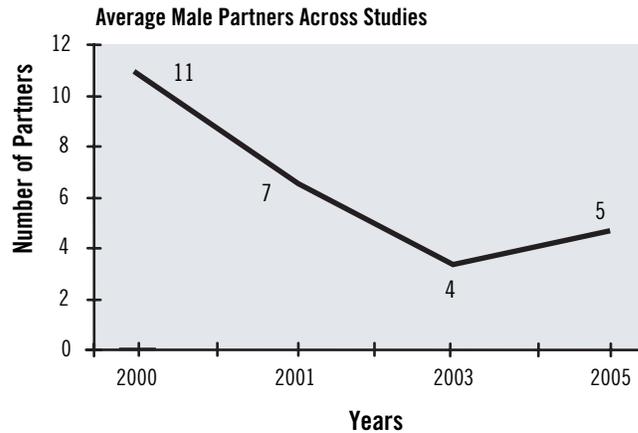
- A PLHA support group, Grace Chapel was formed in 2005 with 10 members and grew to 76 members by early 2006. Inclusion of PLHA and/or affected family members in existing self-help groups addressed the care and support and socioeconomic needs of PLHA and their family members.
- Increase in the uptake of HIV testing were reported due to building strong awareness within the larger community; provision of comprehensive prevention, care and support services; and churches becoming actively involved and engaging PLHA as peer educators, extending nutritional support to PLHA, providing assistance for CD4 counts and providing ART. These activities ultimately helped in reducing stigma and discrimination to a great extent.
- ECS was able to initiate and maintain reach and provide services to OVC after incorporating this as a major strategy and building the skills of its staff in LSE, with assistance from FHI. In reducing STI/HIV vulnerability as well as addictive substance use, the strategy of primary prevention by engaging youth actively through formation of support groups showed results not only in HIV prevention but also in reducing stigma and discrimination related to drug use and HIV.

### **Outcome Assessment of Yaarana (*Friendship*) Project: An HIV prevention, care and support project for MSM and transgenders in Mumbai**

Under IMPACT, USAID/FHI supported The Humsafar Trust (HST), a CBO working with MSM and transgender populations in Mumbai since 1995, for a comprehensive HIV prevention-to-care project from October 2001 to September 2006. FHI assigned an outcome assessment of the project by an independent consultant. The overall objectives were to assess: i) the knowledge and attitude of MSM toward HIV/AIDS; ii) sexual behavior and practices; and iii) health-seeking behavior of MSM. Both qualitative and quantitative review of the project was undertaken. HST had previously conducted four rounds of studies (BSS) to assess change in indicators as a result of interventions. Of the four waves, waves 3 and 4 were used for the outcome assessment as well. The highlights of the outcome assessment are given below:

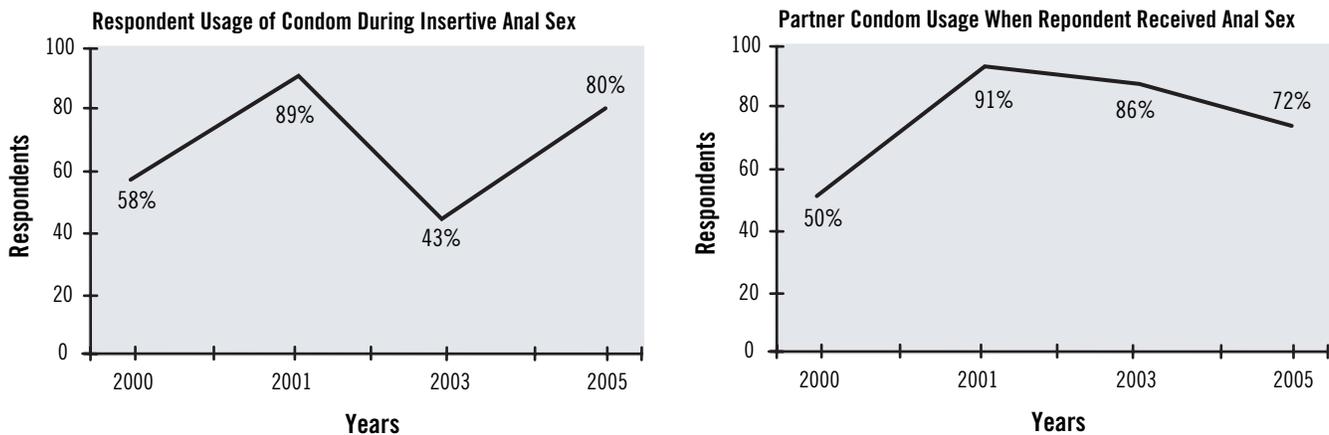
- Under the IMPACT project, HST strengthened HIV/AIDS-related SBC through outreach and community events. At the onset of the project in 1999-2000, MSM showed stigmatizing attitudes toward PLHA. It was encouraging to note that MSM in quantitative as well as qualitative studies reported supportive attitudes toward PLHA. Under IMPACT, HST was able to give a human face to HIV/AIDS and create an enabling environment against stigma and discrimination.
- Repeated BCC sessions by the outreach workers may have motivated MSM to reduce their number and type of partners, thus stabilizing the number of partners over the years as shown in Figure 13.

**Figure 13. Decrease in Number of Sex Partners Among MSM in IMPACT/HST**

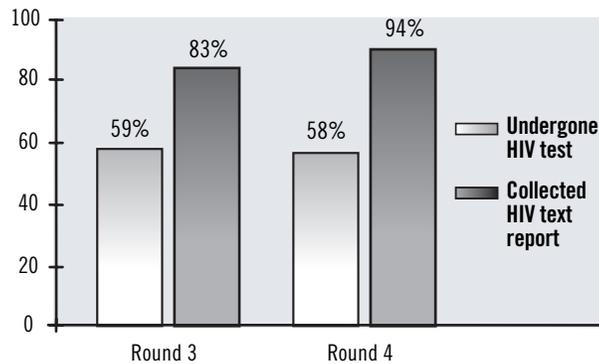


- The multi-pronged strategy of condom distribution through free distribution and social marketing has led to widespread condom availability as shown in Figure 14.
- HST has been able to provide quality STI care services to clients through the STI clinic.
- HST has not only increased access to VCT services but also emphasized HIV testing through BCC. The importance of HIV testing thus has widely spread among MSM exposed to intervention, as shown by increased attendance for HIV test results in Figure 15.
- PLHA have expressed satisfaction with HST’s care and support services, which have helped improve the quality of their lives. This reflects the success of HST’s comprehensive care and support interventions.
- HST has been able to provide a successful platform to MSM in an HST “safe space,” where MSM visit to interact with other MSM and thereby receive community support, as well as obtain information on HIV/AIDS.
- HST’s skill building program has been successful in changing the lives of those MSM who have been employed as a result of acquiring a new skill. This program has generated tremendous goodwill among the MSM community.

**Figure 14. Condom Usage Patterns Among MSM in IMPACT/HST Project**



**Figure 15. Voluntary HIV Test and Report Collection**



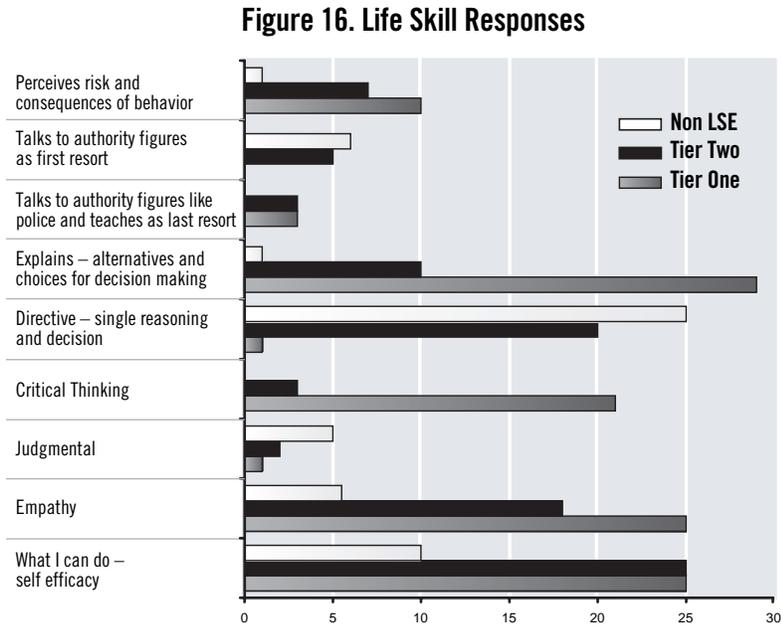
### **Outcome Assessment of Life Skills Education in OVC Programs**

Under IMPACT, life skills education (LSE) was implemented in more than 30 OVC projects addressing at-risk and HIV-infected and affected children ages 10 to 18 years. Through the use of the life skills education toolkit, LSE facilitators in the NGO implementing partners provided information and skills for children to reduce their risk of being infected with STI/HIV and also cope with HIV infection. A consultant conducted an outcome assessment of select OVC projects (10 projects) using both quantitative and qualitative methods. The methodology included interviews, focus group discussion and MLE (Milestones in Learning and Empowerment). Mapping plotted critical implementation “signposts” on a timeline from initiation to more advanced LSE programs. Twelve problem scenarios were selected from the LSE toolkit and pictorially represented. Groups of children (10–18 years) were asked to comment and state what they would do in such situations. Fifteen children from six organizations who received LSE sessions for more than two years (Tier 1), 15 children from four organizations who received LSE for six to 12 months (Tier 2) and 30 children who did not receive LSE (Tier 3) were shown these problem scenarios and their responses noted. Responses were qualitatively analyzed and tallied.



These adolescent girls and boys are involved in a participatory activity as part of the life skills education (LSE) sessions conducted at the Young Women’s Christian Association (YWCA). This session, called “Bad Touch by Body Mapping” helps adolescents and children to understand and deal with complex issues of child sexual abuse and harassment. The sessions are adapted from the LSE toolkit developed by FHI under the IMPACT project.

**Outcome:** Children in well-implemented LSE programs showed improvement in HIV knowledge, perception of risk, attitudes toward OVC and reported changes in risk behavior as shown in Figure 16.



**Interpretation:** Children who received LSE sessions for more than two years (Tier 1) scored better than those who received LSE sessions for six to 12 months (Tier 2) and non-LSE-exposed children in the following areas:

- Increased perception of risk
- Better skills in decision making (more alternatives and choices)
- Improved critical thinking
- Less judgmental
- More empathetic and caring toward other children
- Better self-efficacy skills (confidence in one’s ability)

# V. Lessons Learned

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As a NACO partner, FHI was actively involved in the NACP III design working groups and contributed the following lessons learned under IMPACT to the planning process. FHI also drew on these lessons learned in its involvement with expert groups and in contributing to the development of national operational guidelines, including guidelines for programs for working with children infected and affected by HIV and programs with drug users.

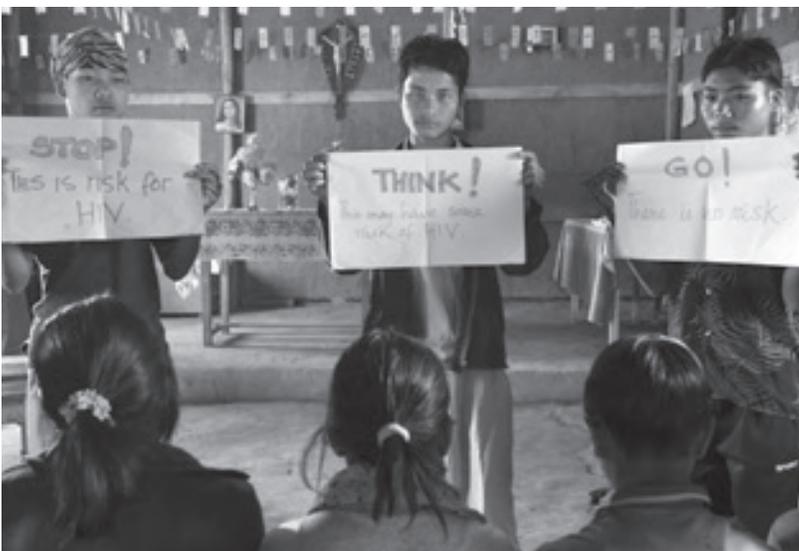
- Effective partnerships and strategic use of limited resources are critical to making an impact on the HIV/AIDS epidemic in a country as large as India. Linking demonstration projects with policy and advocacy work at both the national and state levels has led to wider adoption of innovative program approaches and has enabled FHI to leverage other critical resources to continue program interventions. Under the IMPACT project, FHI and its partners highlighted the success of HIV program strategies that addressed gaps in NACP II and were then included in NACP III and replicated by other funders.
- Greater involvement of people living with HIV/AIDS (GIPA) should not be limited to capacity building efforts. Involvement of PLHA networks is critical in the design and operationalizing of GIPA strategies at the national, state and district levels. The Indian Network of People Living with HIV/AIDS (INP+) demonstrated that with effective and consistent advocacy, GIPA was recognized as a key principle and strategic approach within NACP III. INP+ has also demonstrated that even in low-resource districts, networks of PLHA can develop and manage comprehensive prevention-to-care projects and can be effective advocates for important PLHA issues within the public and private sectors.
- FHI global frameworks and technical strategies formed the technical foundation for programs that were adapted to the local Indian context. The broad IMPACT mandate for HIV prevention, care and support allowed for experimentation and development of new strategies to address the changing HIV epidemic in India. The comprehensive HIV prevention-to-care program approach was a successful strategy among key populations such as drug users, MSM and others, and informed the strategic framework of NACP III.
- The uncertainty of year-to-year funding obligations through global field support limited FHI's ability to develop multi-year project agreement cycles with partners. Longer program planning cycles allow local community organizations to strategically develop long-term plans and can improve staff retention rates.
- While addressing gatekeepers and key stakeholders, there was a need for sensitivity to issues of caste and religion, so that projects did not inadvertently support additional divisions. Initially, it was difficult to bring all groups together to form a common platform, but it is in the best interest of the project to do so. The integration of the three cross-cutting themes—GIPA,

gender empowerment, and decreasing stigma and discrimination—into all IMPACT projects was an effective strategy to broach these sensitive areas and proved to be culturally acceptable to most partners.

- Organizations from different developmental sectors can successfully integrate HIV/AIDS programming into their work, even without previous HIV/AIDS programming experience. FHI’s technical support was beneficial for the organizational development of implementing partners including CBOs, FBOs and NGOs. FHI assisted many community development and child development organizations to integrate HIV/AIDS into their programming for the first time and built the capacity of staff at community and institutional levels and in public and private sectors.
- FHI technical support was very beneficial for the organizational development of implementing partners, including CBOs, FBOs and NGOs. Sustained technical assistance and support was critical in building the capacities of organizations and increasing their knowledge and skills in a variety of technical areas. FHI’s philosophy of equitable partnerships led to strong and positive working relationships with almost all partner organizations.

### **Orphans and vulnerable children (OVC)**

- In OVC programs, it is important to address both vulnerable children who are at high-risk of HIV/AIDS, such as street, working and runaway children, children of sex workers and substance-using children, as well as HIV-positive or affected children and their families and communities.
- Experience has shown that the developmental needs of children are critical and should be taken into consideration to create more comprehensive programs, including HIV/AIDS-focused and non-HIV/AIDS-focused activities. FHI’s child-centered approach and child participatory methodology were successful in helping NGOs develop child-friendly interventions. HIV/AIDS programming can be integrated into existing child development programs, and organizations can increase outreach and complement existing interventions. HIV/AIDS interventions should be comprehensive and include both HIV prevention and the care and support continuum.



Adolescent girls and boys are involved in a participatory activity as part of the life skills education (LSE) sessions conducted at Christian Relief Services—Sneha Bhavan in Chandel district, Manipur. This session is called “Stop, Think and Go.” The activity helps adolescents and children develop critical thinking and problem solving skills. Sessions are adapted from the LSE toolkit developed by FHI under the IMPACT project.

- The strategy of foster care needs to be better understood within the Indian context, especially as to what works and what does not work. It is recommended that operational research be conducted on the feasibility of various models of foster care in the Indian context.
- FHI/India has developed an extensive resource of strategies and tools for working with children who are vulnerable to HIV, those living with HIV/AIDS and those who are affected by HIV in different settings. Sharing of lessons learned and tools with organizations working with children will inform scaled-up response to children and HIV in India.

## **Drug users**

- The technical studies conducted by the Regional Medical Research Center (RMRC) and FHI in collaboration with NACO and other government agencies helped build the knowledge base and fill the gaps in information about drug users. These studies have been effective in influencing government programming and policy and in expanding programs for this important most-at-risk population.
- FHI programming for drug users worked in varying geographic contexts both in rural and urban areas and with different target groups—young, urban migrant males with their sexual partners; rural and urban males with their families; and unemployed young males and female drug users across social classes. These programs demonstrated the importance of following a systematic process involving situation assessment, mapping and size estimation, development of evidence-based program strategies, technical assistance and institutional strengthening of partner agencies in program and technical areas.
- The learning sites have shown that organizations must not only target drug users but also address drug users in general, their sexual partners and their increased vulnerability to HIV/AIDS. The projects implemented have shown the importance of developing a comprehensive intervention that addresses drug de-addiction and sexual health issues. Most organizations that deal with drug users have the required skills and expertise in working on drug issues but have limited experience in sexual health and HIV/AIDS issues and need technical assistance to develop this capacity.
- Programs for drug users in the Northeast region of the country have faced many delays in



Villy Chhetri, a nurse working at “Trinity,” Sahara’s Crisis Care Centre, and Ahal Hanghal (male standing), a healthcare worker, attend to the wounds of a drug user undergoing the detoxification process at the center, located in northern Delhi. The project provided drug users with detoxification, abscess management, STI treatment and other emergency healthcare services and was supported by USAID/FHI from December 2004 to September 2006.

implementation because of the poor law and order situation, especially due to insurgency. The projects have had to devise creative ways to address these delays and the challenges inherent in working in conflict situations. Some of the innovative approaches adopted by partner agencies included involvement of community- and faith-based organizations and sensitization of key stakeholders to ensure uninterrupted project activities.

- There is a need to integrate HIV/AIDS into the three major areas of drug programming: supply reduction, demand reduction and law enforcement. There is also a need for national-level advocacy with organizations working in these three areas for better synergy, coordination and impact on drug user programming.

### **Men who have sex with men (MSM)**

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- The MSM demonstration projects showed that interventions need to be positioned within the broader framework of sexuality, sexual orientation and gender to encourage MSM to feel comfortable enough to participate in project activities. Agencies working on MSM issues need to recognize and fulfill this requirement while designing and implementing HIV prevention and care and support projects.
- It is necessary to build the capacity of several small CBOs to reach larger numbers of MSM. It is recommended that larger CBOs/NGOs with experience in MSM programming mentor smaller CBOs for scaling-up of interventions with the MSM population. As learned from global experience, smaller CBOs should be brought under a larger network/umbrella organization for better access to services, effective advocacy and protection of the rights of marginalized population groups such as MSM.
- Peer education is the most effective strategy to reach “hidden” MSM.
- Networking and linkages with the public health system through sensitization, referral systems and ongoing consultation is an effective strategy for providing treatment and clinical care.

### **Migrant interventions**

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- In India, source, transit and destination projects are new, and a common behavior change communication strategy is necessary, as well as coordination between the partner agencies in the source-transit-destination areas. These components were included in the Tirunelveli-Mumbai project, where branding beyond individual organizational identities (as was initiated with *Aariyur*) from source-destination was shown to be critical to ensuring that migrants and their families understood and knew the availability of services in a variety of locations. There is a need for a holistic development approach to HIV/AIDS and “safe” migration that integrates prevention, care and support needs. Services targeting young male migrants need to be attractive and entertaining to sustain interest over time. Creative strategies must be used to reach out to different ethnic groups—for example, the Equal Access Radio project in Nepal and Mumbai for Nepali migrants.
- Because the push and pull factors for migration and vulnerabilities to HIV are many, including poverty, exploitation, loneliness and separation, a holistic approach is recommended to cater to the many different needs of migrants, spouses, families and communities. HIV/AIDS



Toningam, an HIV-positive widow, is involved in an income generation activity at “Nariyang,” a shelter for HIV-positive women run by Catholic Relief Services (CRS) and Sneha Bhavan in Chandel district, Manipur state. USAID/FHI supported CRS–Sneha Bhavan to implement a comprehensive HIV prevention, care and support project for HIV-positive women and children from August 2004 to September 2006.

programs linked with migration need to develop a strategic vision of safe migration rather than exclusively imparting HIV/AIDS information.

- In communities with HIV-positive individuals, prevention programs need to forge innovative and strong linkages with care and support programs. Because resources are scarce and many families in villages are poor, it is inefficient to separate prevention and care and support needs rigorously, though some division is required for the realistic delivery and management of programs. A feedback loop for referral and services is useful for those implementing primarily prevention-related HIV/AIDS programs.

### **HIV care and support**

- The Positive Living Center (PLC) and Community-Based Voluntary, Counseling and Testing Center (CBVCTC) are program strategies that have been adopted by other agencies. These two strategies have illustrated the importance of mobilizing the community and building the capacity of district-level PLHA networks and communities to enable them to manage PLCs and CBVCTC.
- The demonstration projects have shown that the continuum of care includes community-based, home-based and institutional care and support. Often women and children have no protective place to go after their husbands/parents die. FHI partner agency learning sites have shown the effectiveness of innovative program strategies in both high and low HIV prevalence settings. These strategies include temporary shelter for women and children in crisis, vocational training and livelihood options through linkages with ongoing government programs and plans and community-based self-help groups.
- The home-based care (HBC) projects implemented have demonstrated that the medical approach to HIV/AIDS care is not sufficient and that a comprehensive care and support model is required. This knowledge has resulted in increased acceptance of community- and home-based care programs. It is recommended that home-based care programs network with various agencies and ongoing government programs for improved access to continuum-of-care services.
- The projects have reinforced the idea that private-public partnership is essential for HIV/AIDS care and treatment. In low prevalence, urban settings, where stigma and discrimination exist

and people are geographically scattered, linkage with testing sites is an effective strategy to introduce PLHA to early care and support. Reaching out to all testing sites, such as VCTC, PPTCT, directly observed treatment, short-course (DOTS) centers and private healthcare facilities is essential to develop a wide base to introduce PLHA to home-based care programs. Early care and support services are beneficial for PLHA and their caregivers for both their physical care and psychological support. The HBC program must be flexible and able to provide various care and support services for PLHA and caregivers, including nutrition, employment, legal and psychosocial support.

- The government ART rollout in 2004-2005 has highlighted issues of treatment preparedness and adherence at the grassroots level. Implementing agencies have had to face issues of livelihood as well as the emotional needs of PLHA who are now healthier and hoping for a better economic future.

# VI. Annexes: Highlights of Implementing Partner Activities

## A. Implementing Partners Matrix

NAME	ORG. TYPE	GEOGRAPHIC LOCATION	TARGET POPULATION	BUDGET US\$	INTERVENTION	PROJECT START DATE	PROJECT END DATE
<b>Orphans and Vulnerable Children (OVC)</b>							
Catholic Relief Services (CRS)	FBO	Delhi and Peddapuram in Andhra Pradesh	OVC and PLHA	301,121	BCC, medical, education and nutrition services, psychosocial support, Community and Home-Based Care (CHBC) and referral	Aug. 2002	Oct. 2004
CCDT-CAA	NGO	Mumbai, Maharashtra	OVC and their mothers	242,973	BCC, palliative care, support to OVC and referral	Dec. 1999	Sept. 2006
CCDT-DF	NGO	Mumbai	Vulnerable and at-risk youth and children	267,799	Dance, LSE, counseling and peer education	Nov. 2001	Sept. 2006
Community Aid and Sponsorship Programme (CASP)	NGO	New Delhi	Reproductive-age men and women	49,706	BCC, STI treatment, condom promotion and social marketing	Jan. 1999	March 2001
Community Health Education Society (CHES)	NGO	Chennai, Tamil Nadu	OVC and PLHA	407,887	BCC, CHBC, shelter, training, psychosocial support and LSE	March 2000	Sept. 2006
Community Health Education Society (CHES)	NGO	Namakkal, Tamil Nadu	OVC and PLHA	91,743	BCC, CHBC, psychosocial support, LSE, referral, networking and linkages	Dec. 2003	Sept. 2006
CRS Andhra Pradesh	FBO	Eluru, Peddapuram, Vijayawada and Secunderabad	OVC	493,254	BCC, CHBC, psychosocial support, LSE and community mobilization	Aug. 2003	Sept. 2006
CRS Manipur	FBO	Chandel, Manipur	OVC	136,418	CHBC, BCC, LSE and psychosocial support	Aug. 2003	Sept. 2006
Delhi Commonwealth Women's Association (DCWA)	NGO	Delhi	Communities vulnerable to HIV/AIDS in slums	20,195	BCC, peer education, STI, counseling and referral for HIV testing	Sept. 2001	Mar. 2003
Freedom Foundation	NGO	Hyderabad, Andhra Pradesh	OVC	57,161	BCC, CHBC, psychosocial support, LSE and community mobilization	Dec. 2003	Sept. 2006
PRERANA	NGO	Mumbai, Maharashtra	OVC and their mothers	204,858	BCC, shelter, psychosocial support, LSE, educational support, networking and linkages	May 2000	Sept. 2006
Project Concern International (PCI)	NGO	Delhi	Street and working children	631,733	BCC, healthcare services, vocational training, shelter, LSE and referrals	March 2000	Sept. 2006
Project Concern International (PCI) – BRIDGES	NGO	Pune, Maharashtra and Salem, Tamil Nadu	OVC	258,413	BCC, CHBC, psychosocial support, LSE and community mobilization	Dec. 2003	Sept. 2006
Salaam Baalak Trust	NGO	New Delhi	Street children and other stakeholders	274,002	BCC, shelter, health and medical services, LSE, community sensitization, re-integration with families and networking	Aug. 1999	Sept. 2006
SEEDS	NGO	Guntur, Andhra Pradesh	OVC and PLHA	141,294	BCC, community mobilization, CHBC, LSE, psychosocial support, peer education, referral and linkages	March 2003	Sept. 2006
SFDRT	NGO	Pondicherry	OVC	161,028	BCC, LSE, psychosocial support and community mobilization	April 2000	Sept. 2005
SHARAN	NGO	Delhi, Mumbai	Substance-using street children	256,444	BCC, peer education, detoxification and rehabilitation	Aug. 2002	Sept. 2006

NAME	ORG. TYPE	GEOGRAPHIC LOCATION	TARGET POPULATION	BUDGET US\$	INTERVENTION	PROJECT START DATE	PROJECT END DATE
<b>Orphans and Vulnerable Children (OVC)</b>							
SUPPORT	NGO	Mumbai, Maharashtra	Substance-using street children	116,491	BCC, detoxification, rehabilitation, psychosocial support, LSE	April 2004	Sept. 2006
WINS	NGO	Tirupati, Andhra Pradesh	OVC and PLHA	128,876	BCC, community mobilization, CHBC, LSE, psychosocial support, peer education, referral and linkages	April 2003	Sept. 2006
World Vision, India	FBO	Guntur and Vijayawada, Andhra Pradesh	OVC and PLHA	159,315	BCC, community mobilization, CHBC, LSE, psychosocial support, peer education, referral and linkages	May 2003	Sept. 2006
Young Women's Christian Association (YWCA)	FBO	Najafgarh, Delhi	OVC and adolescent girls at risk of HIV/AIDS	161,951	BCC, community mobilization, LSE, psychosocial support, referral, education and nutrition services	Sept. 2002	Sept. 2006
<b>Drug Users</b>							
Sahai Trust	FBO	Chennai, Tamil Nadu	Drug users, PLHA and their families	148,281	BCC, STI/RTI services, HBC and reducing stigma and discrimination	Sept. 2003	March 2006
SAHARA	NGO	Delhi	Drug users and their sexual partners including spouses	329,810	BCC, crisis care, rehabilitation and referral	July 2003	Sept. 2006
SAHARA – Michael's Care Home	CBO	Delhi	Drug users and PLHA	265,072	Palliative and clinical care, psychosocial care and referral	Dec. 2003	Sept. 2006
SASO	NGO	Imphal, Manipur	Drug users, PLHA and their families	140,010	BCC, community-based detoxification, HBC, STI/RTI services and enabling environment	July 2003	Sept. 2006
SASO	NGO	Northeastern states of India	NGO and CBO working with drug users and policy makers	71,756	Situation assessment studies, technical assistance, capacity building and training	Aug. 2003	Jan. 2006
<b>Men Who Have Sex with Men (MSM)</b>							
Humsafar Trust (HST)	CBO	Mumbai, Maharashtra	MSM and PLHA	459,154	BCC, condom promotion, peer education, psychosocial support, CT and referral	Feb. 2001	Sept. 2006
Indian Network for People Living with HIV/AIDS (INP+) Sahodaran & SWAM	NGO	Chennai, Tamil Nadu	MSM	126,231	BCC, drop-in center, psychosocial support, palliative care, referral for medical care and ART, stigma reduction	April 2003	March 2006
Prakriti-Sahodaran	NGO	Chennai, Tamil Nadu	MSM	76,680	BCC, drop-in center, psychosocial support, stigma reduction	Dec. 2003	May 2005
Prakriti-Snehidan	NGO	Pondicherry	MSM	24,071	BCC, peer education, STI, condom promotion and drop-in center	June 2002	March 2003

NAME	ORG. TYPE	GEOGRAPHIC LOCATION	TARGET POPULATION	BUDGET US\$	INTERVENTION	PROJECT START DATE	PROJECT END DATE
<b>Migrants, Truckers and Workplace Interventions</b>							
All India Motor Transport Congress Society (AIMTCS)	NGO	Delhi and Vijayawada in Andhra Pradesh	Truckers, transport workers, their wives, and PLHA	235,794	BCC, STI treatment, psychosocial support, community support	Sept. 2002	Sept. 2006
Bhoruka Public Welfare Trust	NGO	India and Nepal border	Nepali migrants and sex workers	140,745	SBC, STI treatment, condom distribution and capacity building of NGOs	Jan. 1999	Sept. 2001
NIRMANA	NGO	Delhi	Migrant workers in the construction sector	76,128	BCC, counseling, referral for HIV testing and health services	Feb. 2003	Oct. 2004
SARD	NGO	Delhi	Migrant workers in the organized sector	79,431	BCC, health services, sensitization in the workplace, STI services and referral for HIV testing	April 2003	April 2005
SARDI	NGO	Dharavi, Mumbai and Tirunelveli, Tamil Nadu	Potential migrants and returnee migrants at source (Tirunelveli) and migrants (Dharavi)	297,184	BCC, peer education, referral to STI, CT and care and support services	Sept. 2002	Sept. 2006
Solidarity Centre	NGO	Maharashtra and Tamil Nadu	Trade unions and migrant workers	285,243	Capacity building, BCC and workplace policies	July 2001	Oct. 2002
TISS	University	Mumbai, Maharashtra	Nepali migrants	109,919	BCC, referrals, peer education and social mobilization	Jan. 2005	March 2006
<b>Comprehensive HIV Prevention and Care</b>							
Arumbugal Trust	NGO	Tirunelveli, Tamil Nadu	At-risk population, SHG and PLHA	280,137	BCC, CT and CHBC referral	Aug. 2003	Aug. 2006
ECS	FBO	Tuensang, Nagaland	PLHA, OVC and drug users	127,828	BCC, CHBC, community mobilization and drug de-addiction	March 2004	Sept. 2006
Indian Network for People Living with HIV/AIDS (INP+) HUNS	NGO	Namakkal, Tamil Nadu	PLHA	260,789	GIPA, CBHC, psychosocial support, referral for medical care and stigma reduction	April 2003	Sept. 2006
Peace Trust	NGO	Tirunelveli, Tamil Nadu	At-risk population, SHG and PLHA	160,952	BCC, CT, CHBC referral and palliative care	Sept. 2003	Sept. 2006

NAME	ORG. TYPE	GEOGRAPHIC LOCATION	TARGET POPULATION	BUDGET US\$	INTERVENTION	PROJECT START DATE	PROJECT END DATE
<b>HIV Care and Support and GIPA</b>							
CCDT-Roshini	NGO	Kamatipura, Mumbai in Maharashtra	Female sex workers and PLHA	64,747	BCC, drop-in center, psychosocial support, palliative care, peer education and referral for institutional care	Feb. 2004	Sept. 2006
DNP+	CBO	Delhi	PLHA	34,390	Capacity building and training	Sept. 2002	Feb. 2004
Indian Network for People Living with HIV/AIDS (INP+) GIPA	NGO	National	PLHA	528,895	GIPA, organizational capacity building, advocacy and positive prevention	Oct. 1999	Sept. 2006
Naz Foundation (India) Trust	NGO	Delhi	PLHA and OVC	211,311	HBC, BCC, referral to CT and clinical care	Oct. 2001	Sept. 2006
The Salvation Army	FBO	Mumbai, Maharashtra	PLHA and their families	85,045	BCC, CHBC, clinical care , referral for ART and community mobilization	Dec. 2003	Sept. 2006
<b>Technical Assistance</b>							
AC Nielsen Research Services Pvt. Ltd.	Private Corporate	New Delhi	Policy makers	12,470	Pre-testing of storyline and script for Hindi film	Oct. 2000	Dec. 2001
Blackstone Market Facts	Private Corporate	All India	Migrant population	175,057	Research study	Feb. 2003	Sept. 2004
BMFI Mapping	Private	Maharashtra	Policy makers	64,674	Research	Aug. 1999	Feb. 2000
CHR-Burnet Institute	University	National	NGO, state institutions	155,867	Training and capacity building	May 2002	June 2004
CNA	Private Corporate	Maharashtra	Policy makers	83,802	Research	April 2000	March 2004
DKT	NGO	Tamil Nadu	Program managers of APAC	2,082	Technical assistance and capacity building	May 2002	May 2002
Indian Market Research Bureau	Private Corporate	Maharashtra	Policy makers	99,929	STI healthcare providers study	Jan. 2000	May 2000

NAME	ORG. TYPE	GEOGRAPHIC LOCATION	TARGET POPULATION	BUDGET US\$	INTERVENTION	PROJECT START DATE	PROJECT END DATE
<b>Technical Assistance</b>							
Indian Market Research Bureau	Private Corporate	All India	Migrant population	22,015	Research study	Feb. 2001	Nov. 2002
Indian Market Research Bureau	Private Corporate	National	Policy makers	20,562	Secondary research and mapping	Aug. 2001	Jan. 2002
Lenton Group	Private Corporation	National	Policy makers	48,308	Technical assistance	Oct. 2002	Oct. 2004
MODE	Private Corporate	Maharashtra	General population	16,850	Research study	Jan. 2000	Nov. 2000
MSH	Private Corporate	Maharashtra	Program managers of Avert	71,147	Technical capacity building	May 2002	Sept. 2003
Naz Foundation International	NGO	Mumbai, Maharashtra	MSM	32,640	Workshop	Feb. 1999	April 1999
ORG	Private Corporate	Maharashtra	General population	103,009	Research	Oct. 1999	March 2001
PATH	NGO	Namakkal	Risk population and stakeholders	247,895	BCC strategy	Aug. 2003	Sept. 2004
PATH – Namakkal	NGO	Namakkal, Tamil Nadu	Policy makers	76,940	BCC strategy development	May 2003	Sept. 2004
PRAKRITI	NGO	Chennai, Tamil Nadu	MSM	12,516	Training and capacity building	March 2001	April 2001
RMRC	Government	Northeastern states	Policy makers	169,351	Research study	March 2004	Oct. 2004
SIAAP	NGO	National	FHI implementing partners	31,696	Capacity building and developing counseling protocols	April 2003	May 2004
Take 5 Films	Private Corporate	National	Hindi population	11,896	Developing script of Hindi HIV/AIDS film	May 2000	Dec. 2001
Tata Institute of Social Sciences	University	National	Policy makers	19,716	Needs assessment for HIV/AIDS assessment	Feb. 2000	May 2000
Tata Institute of Social Sciences	University	Nepali migrants in Mumbai	Policy makers	60,314	Research and mapping	July 2004	Dec. 2005
University of London	University	Tamil Nadu	Program managers of APAC	2,634	Technical assistance and capacity building	April 2002	April 2002

## **B. Additional Case Studies**

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### **Case Study 1: Health Worker Mobilizes Indian Community to Seek Treatment and Support**

When Bhadri Jandra discovered that she was HIV-positive in 2003, she counted on the support of her husband, a truck cleaner, and her in-laws, who lived with them in Ongole in Andhra Pradesh. Instead, they shunned the 21-year-old Indian woman when they learned of her status. Frightened and lonely, Bhadri returned to her parents' home in a distant village close to Vijayawada in Krishna district.

Bhadri's fortunes brightened when an outreach worker with the Safe Journey project contacted her in January 2004 at the suggestion of her neighbors. The program, funded by USAID and managed by FHI, sought to prevent the spread of HIV and mitigate its impact on the transport sector through advocacy activities and prevention, care and support services to truckers and their families. Initiated in September 2002, Safe Journey was jointly implemented by the All India Motor Transport Congress Society (AIMTCS), the Krishna District Lorry Owners Association (KDLOA) and the Center for Advocacy and Research. The project focused on Vijayawada because it was a hub for transport-related activities. FHI provided grant management and technical assistance to AIMTCS and KDLOA to implement services in Vijayawada and inform lorry owner associations throughout India about issues concerning mobility and HIV/AIDS.

Safe Journey provided treatment and psychosocial services to Bhadri, and helped her develop a more positive outlook. Bhadri soon became a project volunteer in her parents' village—where people living with HIV/AIDS were confronting discrimination—and motivated other HIV-positive women to seek treatment and support.

*“Before joining the project, I had no future. I was always depressed, but since joining it I have hope,” she said. “My self-esteem has also gone up. I have realized my responsibility as an Indian citizen. I now want to extend the same support to other PLHA.”*

#### **Caring for Her Husband**

After her husband learned in 2003 that he too was HIV-positive, Bhadri moved back to Ongole to care for him in the final stage of his illness, from December 2004 until his death in January 2005. During that time, Bhadri's in-laws developed a better understanding of HIV/AIDS and changed their view of her. They asked Bhadri to stay with them after her husband died, but she decided to move back with her parents.

In September 2005, Bhadri became a community health worker for Safe Journey, helping to organize STI clinics, provide HIV/AIDS information and distribute condoms to women in the trucking community.

*“Now I do not face any stigma or discrimination from my people in this community. I am glad that I, too, can hope for someone else,” Bhadri said.*



Bhadri Jandra, a community health worker with the Safe Journey project, issues medicines to clients at an STI clinic in March 2006. Bhadri helps to organize STI clinics, provide HIV/AIDS information and distribute condoms to women in the trucking community. The Safe Journey project has provided comprehensive HIV prevention and care services to more than 86,000 migrant truck drivers, their spouses and families, cleaners and allied workers since September 2002.

Bhadri, now 25, has remained a volunteer in her parents' village since the project ended on September 30, 2006. She has referred other HIV-positive women to the government VCT center and the ART center in her community, and has addressed large audiences on HIV/AIDS issues. In addition, KDLOA recently gave Bhadri funding to establish a clothing business in Vijayawada, which she is expected to open in February 2007.

*"I do not want to depend on my family for financial support, so I am starting my new business," Bhadri said. "I am confident that I will succeed. As a community health worker, I have a very good name in the community."*

### **Establishing a Sustainable Model for Serving Mobile Populations**

Safe Journey provided services to more than 86,000 migrant truckers, cleaners, workers in gas stations and roadside restaurants, mechanics and their families. Program officials noted that the project has demonstrated how strong local capacity building and program ownership can help establish a sustainable model for providing HIV prevention, care and support services to a mobile group and its family members. Since Safe Journey ended, KDLOA managers have been supporting project activities with corporate funds. The association has also submitted a proposal to the Andhra Pradesh State AIDS Control Society for funding.

FHI has managed and assisted eight USAID-funded projects providing comprehensive HIV prevention, care and support services to more than 390,000 migrants, truckers and their families in India. FHI has provided grant management and technical assistance, and has helped build the capacity of local NGOs (including lorry owners associations) to initiate and sustain HIV prevention and care activities in their respective communities.

## Case Study 2: A Community-Based VCT Center—An Innovative Model in India

FHI is one of the few organizations that pioneered the establishment of innovative community-based voluntary counseling and testing (VCT) centers in response to the growing needs of migrants and their families in Tirunelveli district of Tamil Nadu.

**Tirunelveli** has a total population of nearly 2,801,200, with about 40 percent<sup>12</sup> of the population living below the poverty line; it is ranked third from the bottom on both the Human Development Index and the Gender Development Index, out of 30 districts in Tamil Nadu. Given the poverty in Tirunelveli and the lack of livelihood opportunities, migration continues to be a key factor in HIV transmission—Tirunelveli is one of the high HIV prevalence districts in Tamil Nadu. NACO sentinel surveillance data from 2002 indicated HIV prevalence among STI clinic attendees at 22.75 percent and among women attending antenatal care clinics at 1.25 percent.

With funding from USAID, FHI initiated a comprehensive HIV prevention and care project (Preeyam Nesam) with four implementing partner organizations: Arumbugal Trust, the Center for People’s Education, Aussi-Community Development and Educational Trust (Aussi-CODES) and Peace Trust. Between these four implementing partners, the Preeyam Nesam project extended across four contiguous rural blocks of Tirunelveli, covering 530 villages, 121 village *panchayats* (councils), 12 town panchayats and one corporation area, with total population coverage of about 838,360 people. Despite a vast area of coverage and substantial levels of stigma on the basis of both caste and HIV status, the project successfully demonstrated several promising practices including community-based VCT in Tirunelveli district.

**Why community-based VCT?** Interstate migration between Tirunelveli and Mumbai increased the community’s HIV vulnerability in Tirunelveli district. Until 2002, there was only one government VCT center, located in the district hospital, serving a population of about 2.7 million people. The center was managed by counselors with inadequate training and supervision. Distance, location, hours of operation, lack of cultural sensitivity of the healthcare providers and fear of stigma and discrimination restricted community access to this VCT. The community-based VCT service was thus established to improve access to HIV testing facilities for the semi-urban and rural populations and to reduce stigma associated with HIV testing in the government district hospital setting.

**What is community-based VCT?** VCT for HIV is the process whereby an individual (or couple) undergoes counseling to enable him/her (them) to make informed decisions about being tested for HIV. The decision is based on the principles of confidentiality and voluntarism. FHI/Peace Trust supported an innovative community-based VCT model in Tirunelveli district, focused on maximizing the potential benefits of counseling and testing by providing the services at the household level and at the most convenient locations in accordance with the client’s preferences so as to reduce stigma and discrimination.

**Key features** of community-based VCT in Tirunelveli district were:

- Identification and training of community counselors and other support staff. The counseling



In rural communities of Tirunelveli district, Tamil Nadu, four organizations—Arumbugal Trust, Aussi-CODES, Peace Trust and the Center for People’s Education—collaborate to provide comprehensive HIV prevention, care and support services to youth, children and families affected by HIV and AIDS. FHI supports their work, which includes counseling and testing services offered in people’s homes. The counselor shown above, Sister Chaitanya, provides basic information on HIV/AIDS and pre-test counseling. With the consent of the client, the community nurse, Sharada, sends a blood sample to Peace Trust Health Center for HIV testing. Sister Chaitanya provides post-test counseling and refers the client to treatment, care and support services if required. This initiative has increased access, especially for wives of migrant workers, to prevention services and comprehensive care services for those who test positive.

team included a Senior Counseling Supervisor and one male and one female counselor. All counselors participated in a two-week specialized training course on HIV counseling;

- Implementation of innovative communication and community mobilization campaigns;
- Provision of pre-test counseling services either at a medical camp, medical clinic, field office or at home;
- Drawing of blood samples and transportation of samples to a private laboratory for HIV testing after informed consent;
- Implementation of rapid HIV testing with same-day results in the private laboratory using rapid test kits;
- Initiation of post-test counseling (for all clients, whether they tested HIV-negative or HIV-positive) in the same community setting along with ongoing supportive counseling;
- Provision of condoms with key message of correct and consistent condom use;
- Establishment of linkages to other HIV care and support services; and
- Establishment of quality assurance measures of both counseling and testing.

Project staff provided clients in the community with counseling services and tested community members at convenient times and locations after obtaining informed consent. Staff transported blood samples in cold storage to the base laboratory at the Peace Trust Health Center in Tirunelveli on the same day. The clients’ preferred choices for the location of counseling and testing services were home, a field unit or the medical camps. Based on a very rough analysis, the cost per client/test was about Rs.20. HIV test results were sent to project staff within 48 hours. After post-test counseling, results were shared with the clients.

Several steps were taken to monitor and continuously improve community-based VCT services, including routine supervisory sessions and feedback with the Counseling Supervisor; monitoring of the process and content of counseling services provided (by observing counseling sessions with the consent of clients); weekly meetings with all counselors; and review of counseling notes.

Quality assurance of counseling was the responsibility of the Counseling Supervisor along with the Project Manager. All Counselors used standard protocols for pre-, post- and ongoing

counseling, and HIV testing was conducted only after written informed consent was obtained. Systems were established to ensure confidentiality of test results even in home and community settings. All HIV-positive test samples and 10 percent of the HIV-negative samples were sent to the government reference laboratory for external quality assurance.

**Results:** The project outcome assessment revealed that community-based VCT services provide a greater number of community members—especially rural women—with access to counseling and testing services. During the project period, from September 2003 to September 2006, approximately 4,000 clients sought VCT services. Community-based VCT also resulted in several benefits to the greater community, including enhancing HIV awareness and knowledge, encouraging openness, reducing stigma and stimulating community response to HIV care and support services for PLHA. The quality of counseling and testing services was impressive, with strict adherence to voluntarism, confidentiality and informed consent. The clients who were interviewed expressed satisfaction with the quality of counseling and other services including condom provision.

Based on data from this program, the HIV-positive rate is 10.5 percent among women and 8.3 percent among men. Home appeared to be the preferred setting for drawing blood (40 percent), followed by health camps in communities and the project clinic setting. About 98 percent of HIV test results were communicated within 24 hours and the rest within 48 hours. The quality of the procedures, record maintenance and quality assurance standards were found to be satisfactory. Despite the huge workload, standards were uniform across all projects. The outcome assessment report showed that VCT counseling services at the Peace Trust facility met a high standard, though in some field areas there were issues related to quality of counseling given high staff turnover. The outcome assessment revealed that the project staff strictly adhered to the principles of voluntarism and confidentiality.

Offering VCT services at the community level has met a special need among women who would not otherwise have had themselves tested. ***This is one of the most significant achievements of the project.*** These women saw community-based VCT as a way of ascertaining their HIV status, an important piece of information for women who are unable to negotiate changes in their spouses' sexual behavior. Many of their husbands engaged in risky behavior on business travel, including sex with multiple partners, alcohol abuse and violent behavior. Many women were pleased that services were available close to their homes. As one of them said, *“If this testing center was not available at our doorsteps, I would not have been able to assess my HIV status.”*

### **Lessons learned**

- Community-based VCT offers a highly effective model for increasing access and meeting demand for counseling and testing services in rural populations, particularly among women.
- Community-based VCT serves as an entry point in the prevention-to-care continuum.
- Use of rapid HIV test kits ensured that post-test counseling was provided as soon as possible and that test results were provided within 24 hours.
- Ensuring quality assurance of counseling and HIV testing was an important activity that

required dedicated staff time and funds.

- Staff burnout was a key issue that the project addressed through structured breaks for counselors, periodic debriefing sessions and monthly meetings for all counselors. However, rapid counselor turnover remained a constant challenge.
- A more sophisticated cost analysis study should be conducted to assess the sustainability of this type of intervention, in light of the fact that a substantial proportion of those who used the service were women who would not have ventured out of their homes and villages to undergo testing.
- To ensure sustained low-risk behavior, follow-up with clients who tested HIV-negative is necessary. Given experiences in other parts of the world where availability of drugs has increased risk-taking behaviors, interventions such as community-based VCT need to impart positive behavior change messages through follow-up counseling.
- To assess the impact of this type of innovative model, it is imperative that the project undertake a baseline and end line evaluation. In addition, project staff should produce periodic analytical narrative reports. Only then can such an innovative model be described as a best practice or be considered for scale-up.

# VII. Attachments

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## A. IMPACT India Financial Obligation by USAID

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### Financial Obligation Total and Breakdown by Year

Financial Year (FY)	US\$
FY 97	US\$1,300,000
FY 98	US\$250,000
FY 99	US\$850,000
FY 00	US\$4,100,000
FY 01	US\$1,000,000
FY 02	US\$5,000,000
FY 03	US\$5,500,000
FY 04	US\$3,100,000
FY 05	US\$2,500,000
<b>Total</b>	<b>US\$23,600,000</b>

## **B. FHI and Implementing Partners Publications List**

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### **Implementing Partners Publications with Technical Assistance from FHI**

- “Eating Healthy, Living Healthy,” an information booklet on recommended food habits for PLHA; English, Hindi; 2002; The Naz Foundation (India) Trust, New Delhi.
- “Physical Care of People,” an information booklet on management of opportunistic infections; English, Hindi; 2002; The Naz Foundation (India) Trust, New Delhi.
- “Feeling Positive,” an information booklet on various psychological concerns; English, Hindi; 2002; The Naz Foundation (India) Trust, New Delhi.
- “Protect Your Rights,” an information booklet on the rights of PLHA and legal protection; English, Hindi; 2002; The Naz Foundation (India) Trust, New Delhi.
- “Care Today, Healthy Tomorrow,” an information booklet on care options for PLHA; English, Hindi; 2002; The Naz Foundation (India) Trust, New Delhi.
- “Nurtured Hope,” a facilitators training module for caregivers of children infected with/ affected by HIV/AIDS; English, Tamil; 2002; Community Health Education Society, Chennai, Tamil Nadu.
- “Safe Sailing,” a manual for caring for sexual minorities; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “Know More about AIDS,” a basic information booklet on HIV/AIDS; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “The Right Way to Use Condoms,” a pictorial booklet illustrating correct and consistent condom use; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “Keep Fit, Keep Happy,” a food guide and nutritional chart for PLHA; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “Answers to Your Questions,” information on sexual orientation and homosexuality; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “Humsafar Saanp Seedi,” a sexual health game with snakes and ladders; English; 2002; The Humsafar Trust, Mumbai, Maharashtra.
- “Suneyee Mr. Gopal Ki—HIV/AIDS par ek charcha,” a film on the basics of HIV/AIDS, STIs, care and support for a person living with HIV/AIDS and the need for workplace policies; Hindi; 2002; Solidarity Centre, New Delhi.

- “A Handbook on HIV/AIDS and Related Issues in the Context of the Workplace”; English; 2002; Solidarity Centre, New Delhi.
- “A Situational Assessment Report” to reduce migrant workers’ vulnerability to HIV/AIDS in source communities of Tirunelveli, Tamil Nadu, and destination areas of Mumbai, Maharashtra; English; 2003; South Asian Research and Development Initiative (SARDI), New Delhi.
- “Corridors of Health,” a behavior change communication strategy framework for source communities of Tirunelveli, Tamil Nadu, and destination areas of Mumbai, Maharashtra; English; 2003; South Asian Research and Development Initiative (SARDI), New Delhi.
- “Highway Samachar,” a quarterly newsletter highlighting HIV/AIDS-related issues in the transport sector; Tamil; All India Motor Transport Congress Society (AIMTCS), Tamil Nadu.
- “Hello Mumbai,” a guide to Mumbai for new Tamil migrants; Tamil; 2004; South Asian Research and Development Initiative (SARDI), New Delhi.
- “Aruyir,” a quarterly newsletter addressing vulnerabilities of migrant workers; Tamil; South Asian Research and Development Initiative (SARDI), New Delhi.
- A flip book with information about HIV/STIs and VCTC services; Tamil; 2004; South Asian Research and Development Initiative (SARDI), New Delhi.
- A resource directory of HIV/AIDS services in Delhi; English, Hindi; 2004; the Naz Foundation (India) Trust, New Delhi.
- “A Situational Assessment Report” on the HIV/AIDS scenario in Tuensang district, Nagaland; English; 2004; Eleutheros Christian Society, Nagaland.
- “Changing Lives,” a BCC strategy framework and action plan to reduce the HIV vulnerability of young people; English; 2005; Young Women’s Christian Association, Salaam Baalak Trust, Sharan, New Delhi.
- Hands-on skills training module for HIV/AIDS caregivers; English; 2005; Sahara Michael’s Care Home, New Delhi.
- A manual on home- and community-based care for children infected and affected by HIV/AIDS; English, Hindi; 2005; Catholic Relief Services (CRS), New Delhi.
- A training module for NGO workers to identify and manage street children using substances; English; 2005; Sharan India, New Delhi.

- A training manual for SHG leaders; English and Tamil; 2005; Arumbugal Trust, Tamil Nadu.
- A promotional film on the Dancing Feet Project for children in Mumbai; English; 2005; Shiamak Davar Institute of Performing Arts (SDIPA) and CCDT, Mumbai, Maharashtra.
- “Zindagi Ke Kuch Pehlu” (Some vignettes of life), a set of flash cards on HIV prevention with messages specifically targeted to OVC; Hindi; 2006; Young Women’s Christian Association, Salaam Baalak Trust, Sharan, New Delhi.
- “Socho Aur Khelo” (Think and Play), a board game focusing on HIV prevention messages for orphans and vulnerable children; Hindi; 2006; Young Women’s Christian Association, Salaam Baalak Trust, Sharan, New Delhi.
- A manual on home- and community-based care for children infected and affected by HIV/AIDS; English, Hindi; 2007; Catholic Relief Services (CRS), New Delhi.
- “Nurtured Hope,” a facilitators training module for caregivers of children infected with/ affected by HIV/AIDS; English, Tamil; 2007; Community Health Education Society (CHES), Chennai, Tamil Nadu.

## **USAID/FHI Publications**

### *Technical Documents for OVC Programs*

1. Life skills education (LSE) toolkit for OVC in India; English, Hindi, Marathi, Telugu and Tamil; 2007; Family Health International, India.
2. Protocol for child counseling on HIV testing, disclosure and support; English; 2007; Family Health International, India.
3. Protocol for detoxification and rehabilitation for substance-using children; English; 2007; Family Health International, India.
4. Child- and youth-friendly communication materials to promote HIV prevention; English, Hindi, Marathi, Telugu and Tamil; 2006; Family Health International, India.

### *Technical Studies*

1. Investigating Experiences and Influencing Factors of HIV/AIDS Related Stigma and Discrimination in four regions of India - Behaviour Change Communication Plan; English; 2004; Family Health International, India.
2. Rapid Assessment of NACO-MSJE Collaboration on Integration of HIV/AIDS in Drug Demand Reduction Program in India; English; 2004; Family Health International, India.
3. Mapping and size estimation of drug users in five states of Northeast India; English; 2007; Family Health International, India.
4. Exploratory assessment for extending PPTCT services to community and primary health centers in India; English; 2005; Family Health International, India

## C. IMPACT PROJECT COVERAGE DATA IN INDIA: 1999–2006

### No. of Projects

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
OVC	3	7	8	13	27	34	34	34	34
Drug users	0	0	0	0	4	6	6	6	6
Migrants	1	1	2	5	7	7	8	8	8
Comprehensive Response	0	0	0	0	5	6	6	6	6
Care and Support and GIPA	0	1	1	3	3	5	5	5	5
MSM	0	0	1	2	3	4	4	4	4
<b>Project Total</b>	<b>4</b>	<b>9</b>	<b>12</b>	<b>23</b>	<b>49</b>	<b>62</b>	<b>63</b>	<b>63</b>	<b>63</b>

### No. of Implementing Projects

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
OVC	3	7	8	26	43	43	43	43	43
Drug users	0	0	0	0	5	7	7	7	7
Migrants	1	1	2	7	9	9	10	10	10
Comprehensive Response	0	0	0	0	6	7	7	7	7
Care and Support and GIPA	0	15	15	18	18	19	19	19	19
MSM	0	0	1	2	4	7	7	7	7
Implementing Partners	4	23	26	53	85	92	93	93	93
Technical Assistance	2	8	12	16	21	22	22	22	22
Collaborating Partners									18
<b>Total</b>	<b>6</b>	<b>31</b>	<b>38</b>	<b>69</b>	<b>106</b>	<b>114</b>	<b>115</b>	<b>115</b>	<b>133</b>

### Direct Service Beneficiary by Beneficiary Category

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
OVC	160	905	2,344	5,550	12,031	22,400	31,155	49,455	49,455
Drug users	0	0	0	0	775	10,650	15,587	17,919	17,919
MSM	0	0	3,500	5,100	13,240	23,250	26,499	36,998	36,998
PLHA	323	550	725	1,000	5,973	13,400	22,554	41,560	41,560
Migrants and Truckers	0	0	0	0	65,385	88,300	115,444	122,051	391,180
Community Members (CMM)	0	145	5,602	15,964	44,911	185,923	297,402	520,512	1,070,459
<b>Total</b>	<b>483</b>	<b>1,600</b>	<b>12,171</b>	<b>27,614</b>	<b>142,315</b>	<b>343,923</b>	<b>508,641</b>	<b>788,495</b>	<b>1,607,571</b>

BY PROGRAM AREA:

**I. Orphans and Vulnerable Children (OVC)**

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects	3	7	8	13	27	34	34	34	34
# of implementing partners	3	7	8	26	43	52	52	52	52
Individuals reached	160	1,080	2,559	9,255	31,993	90,908	122,487	362,840	543,841
OVC	160	905	2,344	5,550	12,031	22,400	31,155	49,455	49,455
CMM		145	150	3,605	19,653	67,708	89,740	309,414	490,415
PLHA		30	65	100	309	800	1,592	3,971	3,971

**II. Drug Users**

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects					4	6	6	6	6
# of implementing partners					5	7	7	7	7
Individuals reached	0	0	0	0	1,570	13,175	17,882	24,595	29,406
Drug users					775	10,650	15,587	17,919	17,919
CMM					657	2,162	2,000	5,765	10,584
PLHA					138	363	295	911	911

**III. Men Who Have Sex with Men (MSM)**

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects			1	2	3	4	4	4	4
# of implementing partners			1	2	4	7	7	7	7
Individuals reached	0	0	6,598	9,420	18,865	27,537	26,499	42,874	60,194
MSM			3,500	5,100	13,240	23,250	26,499	36,998	36,998
CMM			3,098	4,320	5,625	4,287		5,876	23,206

#### IV. Migrants, Mobile Population and Workplace

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects	1	1	2	5	7	7	8	8	8
# of implementing partners	1	1	2	7	9	9	10	10	10
Individuals reached	0	0	2,354	8,039	84,361	103,980	129,736	136,763	465,233
Migrants and Truckers					65,385	88,300	115,444	122,051	391,180
CMM			2,354	8,039	18,976	15,680	14,292	14,712	74,053

#### V. Comprehensive HIV Prevention to Care

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects					5	6	6	6	6
# of implementing partners					6	7	7	7	7
Individuals reached	0	0	0	0	70	89,805	186,463	140,021	405,192
PLHA					70	5,099	7,435	12,706	14,143
CMM						84,706	179,028	127,315	391,049

#### VI. HIV Care and Support for PLHA Including GIPA

Category	1999	2000	2001	2002	2003	2004	2005	2006	Total ever supported over the life of IMPACT
# of projects		1	1	3	3	5	5	5	5
# of implementing partners		15	15	18	18	19	19	19	19
Individuals reached	323	520	660	900	533	13,245	22,587	28,115	51,837
PLHA	323	520	660	900	533	1,865	10,245	22,422	22,422
CMM						11,380	12,342	5,693	29,415



