"Challenging AIDS related poverty: interventions with ownership, diversity, reach and innovation for poor and marginalized communities in South India"

ONG/PVD/2005/113-266
01/01/2006-31/12/2009

Final narrative report
01/01/2006 - 31/12/2009
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# ACRONYMS AND ABBREVIATIONS

<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy or treatment</td>
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<tr>
<td>ARV</td>
<td>Antiretrovirals</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>CCC</td>
<td>Community Care Centre</td>
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<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<tr>
<td>CFAR</td>
<td>Centre for Advocacy and Research</td>
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<tr>
<td>CPK+</td>
<td>Council for People Living with HIV in Kerala</td>
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<tr>
<td>CRPF</td>
<td>Central Reserve Police Force</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<td>CST</td>
<td>Care Support and Treatment</td>
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<tr>
<td>CVCTC+</td>
<td>Community Voluntary Counselling and Testing Centre</td>
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<td>DAPCU</td>
<td>District AIDS Prevention and Control Unit</td>
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<td>DD</td>
<td>Double Decker</td>
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<td>DGP</td>
<td>Director General of Police</td>
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<td>DIC</td>
<td>Drop in Centre</td>
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<td>DLNW</td>
<td>District Level Network</td>
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<td>DOTS</td>
<td>Directly Observed Treatment, Short Course</td>
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<td>DV Act</td>
<td>Domestic Violence Act</td>
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<td>EC</td>
<td>European Commission</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FIRM</td>
<td>Foundation for Integrated Research in Mental Health.</td>
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<td>FRAT</td>
<td>Federation of the Resident's Association in Trivandrum</td>
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<tr>
<td>GBT</td>
<td>Gay, Bisexual and Transgender</td>
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<tr>
<td>GFATM</td>
<td>Global Fund for AIDS Tuberculosis and Malaria</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRG</td>
<td>High Risk Group</td>
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<td>HST</td>
<td>Humsafar Trust</td>
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<td>ICTC</td>
<td>Integrated Counselling and Testing Centres</td>
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<tr>
<td>ID Card</td>
<td>Identification Card</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<td>IGP</td>
<td>Inspector General of Police</td>
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<td>IMA</td>
<td>Indian Medical Association</td>
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<td>INFOSEM</td>
<td>Indian Network for Sexual Minorities</td>
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<td>INP+</td>
<td>Indian Network for People living with HIV/AIDS</td>
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<td>IPC</td>
<td>Indian Penal Code</td>
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<td>IPPC</td>
<td>Integrated Positive Prevention Centre</td>
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<td>ITPA</td>
<td>Immoral Traffic Prevention Act</td>
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<td>KHPT</td>
<td>Karnataka Health Promotion Trust</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>KSACS</td>
<td>Kerala State AIDS Control Society</td>
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<td>KSAPS</td>
<td>Karnataka State AIDS Prevention Society</td>
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<tr>
<td>LFC</td>
<td>Life Focus Centre</td>
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<td>LSE</td>
<td>Life Skills Education</td>
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<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MSACS</td>
<td>Maharashtra State AIDS Control Society</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MARPs</td>
<td>Most-At-Risk-Populations</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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<tr>
<td>NACP</td>
<td>National AIDS Control Policy</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>NHRC</td>
<td>National Human Rights Commission</td>
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<td>NIMHANS</td>
<td>National Institute of Mental Health and Neuro Sciences</td>
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<td>NREGA</td>
<td>National Rural Employment Guarantee Act</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
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<tr>
<td>OP</td>
<td>Out Patient</td>
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<tr>
<td>ORW</td>
<td>Out Reach Work(er)</td>
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<td>PD</td>
<td>Project Director</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PIE</td>
<td>People living in the Immediate Environment</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PMC</td>
<td>Project Management Committee</td>
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<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
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<td>PSW</td>
<td>People in Sex Work</td>
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<tr>
<td>PTE</td>
<td>Patient Treatment Education</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RPF</td>
<td>Reserve Police Force</td>
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<tr>
<td>RSH</td>
<td>Reproductive and Sexual Health</td>
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<tr>
<td>RTI</td>
<td>Right to Information Act</td>
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<td>SACS</td>
<td>State AIDS Control Society</td>
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<td>SHG</td>
<td>Self Help Group</td>
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<td>SIAAP</td>
<td>South India AIDS Action Programme</td>
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<td>SM</td>
<td>Sexual Minorities</td>
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<td>SMIS</td>
<td>Selvi Memorial Illam Society</td>
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<tr>
<td>SP</td>
<td>Superintendent of Police</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWAM</td>
<td>Social Welfare Association for Men</td>
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<tr>
<td>S &amp; D</td>
<td>Stigma and Discrimination</td>
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<td>TAI</td>
<td>Tamilnadu AIDS Initiatives</td>
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<td>TANSACS</td>
<td>Tamil Nadu State AIDS Control Society</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<td>TG</td>
<td>Transgender</td>
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<td>THAA</td>
<td>Thamilnadu Aravanigal Association</td>
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<td>TI</td>
<td>Targeted Intervention</td>
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<td>TN</td>
<td>Tamil Nadu</td>
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<td>UNAIDS</td>
<td>The United Nations Joint Program on HIV / AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UP</td>
<td>Universal Precautions</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VCTC</td>
<td>Voluntary Counselling and Testing Centre</td>
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<td>WINS</td>
<td>Women's Initiatives</td>
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<td>WSW</td>
<td>Women in Sex Work</td>
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EXECUTIVE SUMMARY

1. Introduction
This is a four-year project (January 2006 to December 2009), funded by the European Union through HIVOS, the Netherlands, and implemented in the four high prevalence states of India and one contiguous state, through eight CBO & NGO partners. The agencies are Social Welfare Association for Men, (SWAM) in Chennai, the Indian Network for People Living with HIV/AIDS (INP+), The Humssafar Trust, (HST) Mumbai, Sangama in Bangalore, Samraksha, working in Raichur district of Karnataka; Women’s Initiatives (WINS) in Thirupathi, Andhra Pradesh; the Foundation for Integrated Research in Mental Health (FIRM), Trivandrum, Kerala, and South India AIDS Action Programme (SIAAP), Chennai, Tamil Nadu, the lead partner working in Theni District. This report is for the period Jan2006- Dec 2009.

2. Pre-Project Context/ Project’s vision
In April 2004, the Government of India announced the availability of first line ART free of cost for PLHA in Government centers, after the Three by Five initiatives taken by the then health minister. Dr.Sushma Swaraj ( then health minister) declared a strong policy-cum-programme commitment to provide free ARV treatment to 100,000 AIDS patients. It was decided that Government hospitals were to provide treatment in six high-prevalence states and within them to three vulnerable groups: HIV-positive mothers; HIV-positive children below the age of 15 years; and AIDS patients who seek treatment in government hospitals. Thus it was urgent to ensure that people use available counselling, testing and treatment facilities and benefit from them. There were very few centres then for counselling and testing. As they were all established newly, the staffs who were managing these centres were not given any training with regard to the social conceptualization of the epidemic and how the individual is affected. In addition, the socially discriminated groups namely female sex workers and Men who have Sex with Men who were more vulnerable to the epidemic were not having supportive environment in these limited settings. Hence, immediate need was felt by all the partners who were regionally working with the vulnerable communities for several years to envisage a separate community friendly centres which could demonstrate stigma free environment which in turn is expected to increase early HIV testing and diagnosis.

3. Project context
Ever since the HIV epidemic started in the late 1980s, the government’s first chaotic responses finally settled down and finally focused on evidence based factoids. This gave the State enough elbow room to plan out and program its public health strategies around targeted interventions in three main high risk groups. The imperatives were that the main engine driving the epidemic was the sexual route. Unlike all other epidemics before HIV, the new epidemic was concentrated in three highly invisible and stigmatized populations that were not just hard to access but criminalized in law and mostly invisible because of the subterranean nature of their behaviours. Also all three populations were characterized by their focus around “desire” and “pleasure” and thus came into the “moral and ethical realm”, as it were. Not only did these groups not fit into the vast RCH programs of the State but they could not even be integrated into the anti-Malaria or TB control programs in the public health sector. It was therefore necessary to initiate them through a vertical silo program in a semi autonomous body like NACO.
In 2006, the epidemic was highly concentrated in four southern States with one vulnerable State on the west coast. Despite government desparately trying to set up services for these groups, the off take of both the HIV prevention, care and support programs was poor. The biggest factor was that outreach was not translating into proportional intake into either the voluntary testing centres but even the STI clinics set up for the HRGs. The main reason for this was the high barriers of stigma and discrimination against the behaviours of the HRGs, already criminalized and subsequently marginalized. This led to resistance from within these communities to access the health facilities. The lack of confidentiality, judgmental attitudes and fear of disclosure kept the HRGs away from both the STI clinics and the Integrated Counselling and Testing Centres (ICTCs). Finally the only way out was to empower these communities to take charge of their lives, and grow their own capacities in engaging the epidemic. Even as NACP III rollout was being charted out, the HIV prevalence among HRGs now re-named as Most-At-Risk-Populations (MARPs) stood at 4.9 per cent for FSWs, 7.3 per cent for MSM/TG and 9.2 per cent for IDU. Among MSM, the condoms for anal sex with male partners had just managed to cross 50 per cent. Despite spending nearly 67 per cent on prevention programs, the percentage of MARPs reached with HIV prevention programs had just rossed 25 per cent and knowledge levels for correct identification of preventing sexual transmission was just 27 per cent.
In other words, the off take and reach of the massive HIV/AIDS prevention and control program was very poor indeed. That’s the main thrust of Sarvojana. With the coalition of eight partner organizations, all community based groups, over seven ICTCs were first established and operationalised and were up and running with a jump start of HRG members taking up the health facilities being offered. Using these as a focus for community mobilization, the partner organizations each started on documenting the severe stigma and discrimination around the high risk groups. A baseline survey to assess existing levels of stigma and discrimination was initiated and completed by all the partners. This has been a major achievement that cannot be fully quantified.

Some of the major achievements of this cross state partnerships has been advocacy that linked up the HIV prevention programs into other vertical programs like the DOTS and Sputum Negative HIV positive clients’ networks subsequently embedding into the government’s health infrastructure. The linkage to the RCH program allowed the partners to advocate against discrimination against children and a letter to the Chief Justice of States resulted in preventing the expulsion of HIV positive children from school, for example. Similarly, the ICTCs became a link in extending child vaccination and antenatal care into the RCH program thus making the ICTCs useful “ripple-effect” foci for the government’s much needed boost for child welfare in the HIV program.

Huge challenges have been thrown up by Sarvojana. Dealing with CBOs and increasing their capacity has meant a very high turnover of staff and sudden need for new networks of HIV positive people who were marginalized by the more formal networks. Besides the lack of accreditation by the various SACS, this led to total lack of financial support from them and subsequent protocol that lay outside the operational guidelines of NACO. This lacuna has to be looked into if there has to be a validity and docking in of the ICTCs started by the partner agencies into the NACO network and CMIS.

Throughout the four years starting January 2006 project period, the scope of the project has been to expand and finally linkups into the public health system by fighting stigma and discrimination through massive community mobilization and participation in the HIV prevention programs. This has not been without various hurdles that included lack of self worth and the marginalized communities themselves having little or no capacity to begin with. Sarvojana thus started with a negative charge and raised the social visibility of onward march of marginalized communities in the country.

That this was done through difficult partnerships spread over so many States in a truly participatory manner is the biggest achievement of Sarvojana and we can be truly proud of this benchmark.

FINAL NARRATIVE REPORT - (jan 2006 – dec 2009)

1. Description

1.1. Name of beneficiary of grant contract:
Humanist Institute for cooperation with developing countries (Hivos)

1.2. Name and title of the Contact person:
Ria Hulsman, Coordinator Office for Donor Relations

1.3. Name of partners in the Action:
South India AIDS Action Program (SIAAP)

1.4. Title of the Action:
Challenging AIDS related poverty: Interventions with ownership, diversity, reach and innovation for poor and marginalised communities in South India.

1.5. Contract number:
ONG/PVD/2005/113-266

1.6. Start date and end date of the reporting period:
01/01/2006 – 31/12/2009

1.7. Target country(ies) or region(s):
India
1.8. **Final beneficiaries &/or target groups** (if different) (including numbers of women and men):

7000 PSW (ages 14-60), 20000 GBT (ages 16-50), 150000 (ages 5-50) and 50000 PIE; 200,000 other indirect beneficiaries including village, government and private heath care workers, legal and judicial personnel, local and regional government officials.
2. Assessment of implementation of Action activities

2.1. Activities and results

| Result – 1 | Improved quality of life of PSW, GBT, PLHA, and WRE through improved health seeking behaviour at Community based Voluntary Counselling, Testing, Support and Care Centres (CVCTC+), and through increased assertion of rights for equitable HIV & AIDS prevention, treatment delivery, care and support services. |

1.1 Establishment and operationalization of 7 community based voluntary counselling, testing, support and care centres (CVCTC+) as hubs to advocate against stigma & discrimination.

The first key activity was the establishment and operationalization of Community Voluntary Counselling and Testing Centre (CVCTC+); the Plus symbol denotes that the centres not only render counselling and testing services but also provide additional services like care and support through appropriate referral and follow up. The partners decided upon the sites of the CVCTC+ after a community consultative process. The choice of the sites depended upon HIV prevalence, density of marginalized group, the livelihood and social activities in a geographical area. The decision also took in to account the proximity to the ART centre so that the effective linkages could be established during the project period. The establishment included identifying the premises where accessing for the community would be comfortable and where the neighbourhood were little open to accept the movement of the community in their vicinity. All CVCTC+ were established with in the first six months of the project start. At the end of first year 7 CVCTC+s had been established, fully staffed and trained.

Out of 7 CVCTC+, four were located in the major state capital of Mumbai, Bangalore, Chennai and Trivandrum and other three centres were located in the district centres of Karnataka at Raichur, of Tamil Nadu at Theni and of Andhra Pradesh at Tirupati. Whether, in major cities or in smaller locations, easy accessibility by the target population to the centres was kept in mind. In the process of site selection and identifying the place for CVCTC+ the communities were actively involved. The centres were managed by coalition member in partnership with the target communities and to further operationalize, agreed for an ethical guidelines relating to confidentiality, principles of respect, recognition and reliance and preferential access for the communities. These guidelines were drawn keeping in mind the operational guidelines given by NACO. The staff was also selected from the members of the community wherever possible. They were given special training during the induction period by each partner, making them understand the philosophy of the project and what were the key objectives and deliverables. Each staff member was given a clear road map on how to proceed in their work, for example for an outreach worker, the areas were clearly marked after taking in to consideration various factors like concentration of target people, time at which outreach activities will be effective, assessing the other priorities of the target groups etc. It was further emphasized that quality of service is important than mere numbers as it was the common understanding that the whole HIV epidemic is all about numbers.

The centres served as drop-in-centre (DIC) where the community was encouraged to drop in at any time, relax, share emotions with peers or seek peer counsellor, take condoms and discuss health issues and other specific issues with regard to violence, stigma etc. The CVCTC+ over the years have emerged into hub of various community activities apart from the activities that were envisaged in the proposal. For instance in one centre young girls were given life skill education and in another it was known as a help centre or coordinating office to get all information regarding various welfare measures offered by the states to various disadvantaged group like widows, handicapped or old people and in the third it was used as a link for carrying out government programmes like “pulse polio”. In short CVCTC+ was established by applying “core ethical values and principles of testing, treatment and increased credibility”.

Each centre had a team consisting of project officer, counsellor, part-time medical doctor, nurse, lab-technician, outreach workers, accountant and administrative assistant. Each staff member was given appropriate training for example if a lab-technician did not have experience in HIV testing then he/she was sent to a HIV testing facility namely ICTC for a week’s time to understand about different methods of testing, maintenance of various records, how to store the kits and send the samples for external quality verification etc. The documentation was kept simple but at the same time contained all required information as specified in operational guidelines. Apart from the individual training given by the partner organization, four combined trainings which were common across the board were given. They are as follows:
• Baseline research training which enabled research participants to understand the need for such research, how to collect quantitative data, how to conduct FGDs and KIs and coding of documents.

• Accountants of all partner organizations were updated on EU requirements and audit procedures.

• Vision and philosophy behind the coalition and project to all project officers gave an understanding the spirit behind the project. It also gave an opportunity to understand the nature of other organization’s work.

• Treatment education given to project officers and counsellors enabled them to get technical updates on ART, understanding the practical problems relating to adherence, resistance to drugs and side effects.

To quote the external evaluator “The founding organizations,, both philosophically and from their own prior experience in responding to the HIV epidemic, committed themselves to responding to the needs as human and social beings of their communities of interest, rather than just using them instrumentally to reduce HIV transmission.”
1.2 Sensitization and mobilization of target communities in project areas to access CVCTC+ and other existing services.

The traditional methods of mobilizing the target groups were adopted. They included one-to-one and one to group sensitization meetings, village education meetings, meetings with village leaders, youth, women’s self help groups etc. In outreach work, a snowballing technique was adopted, with the outreach worker getting familiarized with one key community member who would then help in identifying other members who may need centre’s services. However, shortage of outreach staff, long distance travel and meagre gathering at cruising sites due to increased use of cell phones by the community to contact clients posed a challenge to outreach work.

Hence different strategies like appointing part time outreach staff and engaging staff from other projects to cover some areas were adopted. Outreach timings had to be changed to early morning hours and late evenings to meet with the community. Apart from these the centre staff took active part in religious fair or Independence Day celebrations at villages where the mass were sensitized around issues of stigma and discrimination. Resolutions were passed, in many Panchayats (village governance structure) against discrimination of affected / infected persons in the villages. Follow up on violations of these resolutions were taken up by the staff at the centres.

INP+ though did not establish CVCTC+, appointed outreach workers who encouraged and motivated the members to access public health and support services from government hospitals.

All the combined effort of CVCTC+ staff and INP+ resulted in a significant coverage in the four years. The total number of outreach in the four years is 3,48,441. The highest reach was in the third year as shown in the graph below.

Mobilizing people to access services at the centre was challenging. The various reasons that were identified were having to spend money towards bus fare, as the CVCTC+ is located far away from their residence, timings of the centre and doctor’s availability and incentive provided by other NGOs to community members on a visit basis either in the form of cash or kind. Hence after review at the end of the second year specific strategies were adopted to have an extended coverage by extending CVCTC+ services to communities outside the centre. These services included imparting STI education, demonstrating condom use and giving them condoms etc. In addition, one simple card was distributed which had information regarding symptoms, treatment, and awareness of their rights. The community was also encouraged to report any cases of violation of human rights to the project-in-charge and to educate the entire village through a village education process and building a volunteer base, etc. That card also had the telephone number of contact person whom they could access anytime for help with any crisis like police harassment or rowdies problem or discrimination faced in the neighbourhood. Also, some agencies consciously planned campaign work, which produced good results and outcome.

Some centres linked the community to avail Government sponsored schemes like old age pension, widow pension and disability aid. Networking with other organizations in the welfare field like providing
school books for children, to get the children admitted to hostels etc. increased the coverage. At some places CVCTC+ was used for pulse polio immunization.

This holistic nature of the CVCTC+ was a key factor in supporting the community through counselling and training on positive living. It has also paved way for testing without fear of stigma for people with self risk perception. The CVCTC+ has provided an enabling atmosphere for the PLHIV to disclose their status to their community during support groups and other meetings.

**What worked most were the connections among people namely people living with HIV, care providers, care seekers and volunteers from the general community**

The experience had taught that when working with marginalized and oppressed groups, the establishment of CVCTC+ has to be complemented by programmes which reach out into these communities and encourage and motivate them to attend.

The uptake of services increased over the years. 44,219 people accessed services at the centre out of which 18,865 went for pre test counselling, 17,688 consented to test and 1,587 tested positive.

All those tested positive were immediately referred to ART enrolment as this was one of the main vision of the project, linking the positives from marginalized group for early diagnosis and enroll them to ART, which aimed to cover first 1,00,000 positives free of cost. Also, to build the collective strength of positive people, all the positives were referred to the respective district level networks.

**Observations**

1. **Community ownership and Community empowerment:**
Both internal and external evaluation has indicated community ownership on the basis of measures used in indicators, like increased usage of service, increased trust in centres, community members trained as staff, participation of the community in decision making etc. The basis of project success in
the area of community empowerment has been practices of giving respect and treating marginalized population with dignity.

This was achieved through taking proactive corrective measures, when at the end of the second year it was seen that community ownership was not forthcoming, especially from PSW group where most of the project staff were from the non-community. In order to increase community ownership, one of the methods followed was pairing community with non-community and slowly developing their skills. The community consultations were done periodically and their need in the areas of empowerment was identified. Apart from the skills that were needed to perform their tasks with regards to CVCTC+ project, they were also additionally trained in using computers, to speak English, etc.

However, clear demarcation was seen between the staff and non-staff members. The staff members were expected to do everything as they received salaries. Sometimes, even when the staff had taken leave for valid reasons the other community members would not volunteer to do even the simple tasks like cleaning or putting things in order. They would act in a way that the centre was their right and they were entitled to use it for free. Again, it was difficult for community staff to draw any boundaries between their role as staff of CVCTC+ and their being member of the community. Sometimes they displayed their authority as staff which resulted in widening the gap.

2. Outreach:

Initially outreach was difficult due to limited staff but in the following years different strategies were adopted by different partner organizations like using the project staff from other projects, by employing more outreach staff on part time basis, by mass advertisements in local train, buses and also making the CVCTC+ services at places where people could use it like running satellite centres or giving counselling, education, referral and condoms during field visits. The outreach staff was appropriately trained to impart these services effectively.

Special efforts were taken by the CVCTC+ team to accompany the positive person at the time of enrolment and help him/ her through baseline investigation, familiarizing with the environment in the hospital, introducing them to peer-counsellor from the positive networks and ART counsellor. The people who needed treatment for STI/OI/ TB were referred to appropriate places. Apart from counselling and testing, people regularly used the drop-in-centre where they would rest, relax, and discuss their problems with other members of the community and community counsellor. Women both sex workers and general community had easy access to condoms although there were several avenues created by government set up like anganwadis or village health nurse. However, it is seen that it is still difficult for woman to have access due to their personal identity in the village, where as in the CVCTC+ set up it is anonymous.

Many centres also experienced good attendance in the support group meetings held for positive people. Initially it was opened up only for people who were tested positive in the CVCTC+, but over a period of time the flow of people increased as the meetings offered a safe platform for people to share their emotions, educate themselves about adherence, side effects of drugs, importance of tracking CD4 count and maintaining good health through locally available nutrition. All this created an atmosphere for positive living and increased confidence and self-esteem and promoted health seeking behaviour.

All the activities were done as per the committed time frame. However, at the end of second year it was felt that the numbers as committed in the log frame was unachievable due to reasons of downward estimate of HIV figures by UNAIDS. Hence, keeping in mind the target reached in the two years, population of target communities in the geographical area, limitations of outreach such as the inability to reach out to mobile access to MSM/WSW, downward revision of estimates were made and new targets were 15000 PLHIV, 7000 PSW, 20000 MSM and 50000 PIE.

**PLHIV**

Estimates as per proposal: 100000
Revised estimates: 15000

**Explanation:** The new NACO estimates of July 2007 showed a dramatic decrease in the number of PLHIV. The new estimates were brought down by 66% as compared to the data available in 2005. In the wake of new estimates, with reduced number of HIV positive in India it was found that reaching out to 100,000 PLHIV was not a realistic figure. INP+ participated in the meeting to rework on the achievable numbers in the project. They estimated that around 15,000 PLHIV would have received
services at the end of the project through the program and its linkages with the government of India ART program by all partners in five states.

**PSW**

*Estimates as per proposal: 25000*

*Revised estimates: 7000*

*Explanation:* In the case of PSW it was discussed that the actual number in some regions were much lesser than what was projected in the proposal. The new revised figures were based on the sex mapping of the work sites of sex workers being covered in the project area. There was duplication in the figures mapped in the past at various sites as the same population was counted more than once, owing to similar projects being supported by different donor agencies.

Currently, Theni is the only centre, which is focusing on WSW, and the TNSACS estimates state that there were only 1500 WSW in the district. Additionally, the presence of TAI (Tamil Nadu AIDS Initiative) who have mass tested the WSW in the district, during their mass campaign in December 2007, made it difficult to achieve the target numbers. If SIAAP decided to extend the CVCTC+ services to other two districts with the same budgets then it may at best have reached 3000 in the next 20 months. With contributions from other partners the total number of WSW that could be reached is 7000.

**GBT and PIE**

*Estimates as per proposal: 20000 and 50000*

*No revision in these estimates.*

*Explanation:* In case of high risk group of GBT the prevalence is going up and PIE is constant. As assumed in the log frame, it was possible to achieve the above mentioned results as the project received timely inputs and resources as proposed from support agencies.

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**Result 2:** Improved quality of services for care, treatment and support for marginalised and vulnerable groups.

### 2.1 Baseline survey in specific project areas to quantify existing levels of stigma and discrimination among target communities.

The baseline survey was done in mid 2006 to assess existing levels of stigma and discrimination among target communities in the project areas. The findings would facilitate in identifying key areas where the work needed focus. Mixed methods were used to enable both qualitative and quantitative assessment. The formats for survey questionnaire, guide for both FGD and KII were framed after the research team was trained in research methodologies. Then after the review of the formats, a pilot study was conducted. The formats were suitably changed after the necessary modifications based on the inputs received during the pilot study. An exhaustive operational manual was prepared. At each stage of baseline survey, discussions were held with the relevant community advisory board and their approval was obtained to ensure community participation in the research.

In all 401 interviews, 32 FGDs and 14 KIIs were completed. Information has been collected from PLHIV, WSWs, MSMs and PIEs. Data gathered in the survey has been collated. They were broadly categorized into qualitative and quantitative findings. The former describes types and levels of stigma and discrimination (S&D) felt by members of different groups and provided case studies as examples. Various contexts of S&D were identified for each group under family, health care settings, government agencies, media, workplace, educational institutions, police, rowdies, clients of sex workers, neighbours and society in general, stigma by association and self stigma. S&D takes various forms namely verbal abuse, refusal of treatment, social isolation, physical and sexual violence, extortion, false allegations, betrayal of confidentiality about the person’s positive status, loss of work and expulsion from school. In addition MSM/Hijra are denied of their civil rights for example they are not able to get ration card or open bank accounts. All the groups carry the burden of self stigma which causes guilt and self-blame.

Quantitative findings have been derived from data obtained from the same group. Indicators used in collecting and tabulating information were knowledge about HIV/AIDS, testing, discrimination in health care settings, forced sex, violence and harassment, psychological support. For general population different set of indicators were used to measure knowledge and prejudice.

The findings describe public attitudes towards these vulnerable groups through description of opinions expressed during FGDs of the general population. These show that opinion is divided regarding acceptance of WSWs, MSMs. There is also a tendency towards superficial moral judgments.
Key findings:
About HIV knowledge
- Among PLHIV 75% were aware of at least three correct modes of HIV transmission, 89% were aware of how to protect themselves from getting HIV through sex.
- Among PIE only 47% could identify three correct modes of transmission and only 36% were aware about preventive measures.
- Among WSW 91% were aware about sexual mode of HIV transmission and that condom use can prevent transmission. Only 66% were aware that needle sharing could also spread HIV.
- Among MSM and Hijra 64% were aware about 3 modes of transmission though 88% were aware about sexual mode.

Voluntary and mandatory testing
- Among PLHIV about 50% reported that informed consent was taken.
- Among WSW 60% reported that informed consent was taken before testing.
- Among MSM/Hijra 94% reported that consent was taken.

Stigma and Discrimination
PLHIV
- 57% of PLHIV experienced at least one incident of discrimination.
- 87% experienced one incident of discrimination in health care settings.
- 69% of them had self-stigma with feelings of shame, guilt, and self-blame.

WSW
- 40% reported forced sex.
- 37% reported physical abuse.
- 55% reported verbal abuse.
- 45% reported threat to life.

MSM
- 46% reported forced sex.
- 44% reported physical abuse.
- 66% reported verbal abuse.
- 24% reported threat to life.

Perceptions among PIE:
- 89% feared that HIV can be contracted through non-invasive or casual contact.
- 24% shared that they would feel ashamed to be associated with PLHIV

Most of the members from WSW and MSM reported that they get psychological support from their community members.

The base line report was translated in the local languages and disseminated to the participants. Based on the report action plan was drawn up to work closely with health care settings, to plan activities which would educate people in the environment, form and strengthen the community groups, give them appropriate trainings and guidance to enable them to manage their affairs.

2.2 Meeting of self help groups of target communities to develop a plan of action to identify and address specific cases of stigma and discrimination, educate public and seek legal redress when necessary.

From the beginning of the project period CVCTC+ offered a conducive atmosphere for the formation of informal community groups. The members met at the CVCTC+ on a regular basis, discussed their emotional, social, physical and other problems and challenges which they felt in their day to day living. Based on the findings of the baseline report which clearly gave direction that communities derived maximum support from their fellow community member, all partner organizations from the second year of the project invested their resources and energy to build these groups. The members were collectivized. The meeting was organized periodically once in a fortnight or a month. The leaders from the groups were carefully identified, given appropriate training. The trainings included leadership building, organizational development, basic knowledge of Sec 377 of IPC and ITP Act, communication, English speaking skills, using computer and internet so that they have adequate capacities to manage and run a CBO. Regular trainings were organized for active community members on gender and

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1 This report has been send to EU together with Interim report 2006 (Annex 8) in March 2007
women’s issues. Specific trainings on NREGA, RTI etc enhanced their understanding on value based work and how it impacts processes.

Each partner organization has promoted and encouraged in building and strengthening of community groups. In all 30 both small and big groups were formed by different CVCTC+. Some of these groups have emerged strong. These groups have established themselves well and are able to coordinate with other NGOs and other social groups and bring their issues to focus. Each organization apart from forming their own community groups for taking up the specific issues of stigma and discrimination or any violence or violation of basic human rights also accompanied their members to treatment and care services in hostile environments; constantly worked towards getting better response from the health care settings. Some organizations which closely work with PIE follow a community based approach where the whole community is educated. Yet another organization chose not to form any group but strengthen the hands of newly formed women’s network. Some organizations which tried to promote groups among PIE failed but they observed that as individuals they were very helpful.

The members from 19 community group met for the first time in Dec 2008. The key discussions were held around issues of health, discrimination in hospitals, in other social settings, police violence, livelihood problems and concerns about their children. Each person’s story was of great importance as it brought these groups together, gave self confidence and courage.

Second time the members from these groups met for 3 days in Dec 2009. In the workshop they were able to articulate their experiences/gain being part of these groups. The key changes which the groups felt being together were as follows:

- Injustice to women is addressed and voices of women were heard in police station
- Increase in the number of people accessing services both at CVCTC+ and Government health care.
- By constant interaction and inviting the officials to participate in the community activities, Changes are seen in the attitude of people in the immediate environment particularly police, local bodies, hospitals and RPF.
- Creation of ownership among community. Highlight being formation of Social forum bringing 5 community groups and 54 social groups under single umbrella in Kalyan CVCTC+.
- Capacity of community to handle issues enhanced.
- Easy accessibility to condoms by women.
- Increase in percentage of kothi and DD going for testing.
- Violence has come down because of sensitization in the slum as most of the clients of kothi are from these slums.
- Early access to information and services leads to increased self risk perception.
- First time in this project support group meeting for affected and infected children were pioneered by INP+.
- ART adherence has improved to 60%.
- Nutrition has improved longevity.
- Attitude towards PLHIV changed in the community. For example Income generation programme initiated by Panchayat in Ariyalur district.
- Improved health of positive people

Apart from these groups each partner organization has also encouraged positive people to informally meet for mutual support, though most of them were linked to the respective positive networks at the district level. The following are some of the activities which these groups performed on a regular basis.

- **Support group meetings** initially were facilitated by the counsellor but later there were volunteers from the group who would conduct meetings taking turns. In these meetings individuals were given space to ventilate and share emotional and other psychological issues. In all centres it was seen that this meeting was a great success. The project linked the identified positives to the district level networks but due to the limitations of staff and other resources the networks were not able to cater to the needs of all the members. Essentially in all the meetings some time was devoted to adherence of ART. The members were encouraged to share their CD4 count among the group members. This kept both the members and group motivated. Essentially there are three factors that have helped women to live well without having to resort to ARV therapy. They found support from women who were similarly afflicted from counselling groups that gave them hope; through these groups they got access to doctors who treated their opportunistic infections in time and they learnt how to look after their health through a combination of diet and precautionary measures.

- **Support group meeting for infected and affected children**: This was the first time ever, support group meetings were held at pediatric ward where cultural and other events were organized for children on the eve of major festivals. To impart life skill education skits and plays were enacted.
They were also given counselling support. Very often painting activity was organized for children to express their emotion.

- **Peer support:** It was observed that the members support each other at times of crisis. They voluntarily take turns to attend the group member when he/she falls sick and is admitted for treatment in hospital. As most of the members in the group are women, they also take care of children of the woman who is hospitalized. They also contribute little sum of money say Rs. 5/- or Rs.10/- for very needy.

- **Nutritional supplements** are provided in the form of Dates, full grain pulses and health drinks for infected children. There were also practical demonstration classes which were conducted periodically to both old and new members to make them learn to get nutritious food from the local available resources like sprouts, beetroot, carrot, jaggery and peanuts etc. Nutrition support helped in increasing the man days worked, children attendance was better in school.

- **Training** for peer counselling were given on ongoing basis who in turn were asked by Government hospitals to render help in ART centres. This also facilitated in creating familiarity with the staff in ART centre. They in turn attended the clients referred from CVCTC+ with care.

- **Linkages:** The other linkages available in and around CVCTC+ for positive people have been strengthened. Sometimes, these support group meetings are held in the premises of care homes as it would reduce the fear in the minds of positive people, they will be familiar with the staff and environment. Linkages are also well established with other NGOs and missionaries where they get direct support like stay homes or treatment, indirect support like getting the children admitted to residential school.

- **Funeral services:** One agency (SWAM) is providing van to carry dead bodies of PLHIV to crematorium.

- **Life Skill Education (LSE)** for girl children of female PLHIV have been provided at WINS CVCTC+ as female PLHIV are particularly apprehensive of their Girl children's future, after attaining puberty.

- **Community Care Centre (CCC)** destitute women and orphan children have been linked to community care centre for arrangements for stay on a temporary basis.

- One positive group **Sadhane** which is registered and has a governing board received a contract of implementing the Samastha program funded by KHPT (USAID) in Ramanagar district. The program aims to prevent HIV-AIDS, providing care and support for WSW, general public, supporting the youth and vulnerable orphan children in 86 rural villages in Ramanagar district. Suraksha and Sangama are providing technical support in implementing this program. The project has an Integrated Positive Prevention Centre (IPPC), in Ramanagar taluk of Ramanagar district. Sadhane board members are supporting this program by providing their time voluntarily.

Similarly in Jan 2009 Sadhane received a pilot project directly funded by NACO towards reducing stigma and discrimination in Ramanagar, Bangalore Rural, Bangalore Urban and Dharwad district. This project is for 15 months and is ongoing.

The key observation about positive women were “Poverty and hunger are real issues for woman with no support system, they are too scared to fight for their rights. They attended meetings, joined hands to get some benefits but are too constrained for time to devote for any special cause. However, they participate wholeheartedly in discussions which would offer solutions to the issues. They motivate each other in treatment adherence and took active interest in discussing inheritance related issues.

### 2.3 Advocating with government, private and community agencies for action against stigma and discrimination of target communities.

It was chiefly advocated with government by negotiations, dialogues and actively getting involved in various training programmes sensitizing government personnel about marginalized groups. It was done through representations to relevant SACS, dharna or protests and also intervening through filing cases in the court of law.

All partner organizations as well as community groups/ community staff/ project staff handled all cases of stigma and discrimination reported to them. Some of the key issues that were taken up by different organizations included the following:

- 39 WSW were thrown out of their legally occupied homes by the moralists in Kozhikode with the support of police. The members decided against the agitation as it would cause imprisonment of community members. With the help of FIRM and community members they moved the High court of Kerala seeking direction to the state DGP to give police protection to the evicted sex workers. However, still the implementation part is not completed as it involves action against police and lack of local support from other human rights organization.

- Another incident when HIV positive person was refused treatment at the hospital after he met with an accident, the agency moved the National Human Rights Commission. NHRC asked the KSACS
When Tamil Nadu AIDS initiative funded by AVAHAN decided to do mass testing of women in several districts, women reported that consent was not taken, principles of confidentiality were not adhered to. Immediately agency working in the area conducted a research and collected data from 150 women and compiled the findings, gathered likeminded CBOs and NGOs alerted State AIDS Control Society and successfully stopped further testing.

- 5 positive children who were inmates of an orphanage were thrown out because of their HIV status. The agency tried to resolve by conducting awareness by inviting popular film personality. But when it did not yield desired result, FIRM moved the High Court of Kerala.
- Several cases of stigma and discrimination at government hospitals were handled by outreach staff and counsellors, who constantly visited hospital and kept close watch on the services that were provided. Whenever there was any deficiency it was immediately taken up till corrective measures were taken.
- Community groups also took up cases of discrimination that imposed restriction to their fundamental rights. Police exposed seven of the alleged members who had come to attend the birthday of a friend, in front of media as a gay and this news was broadcasted on many news channels. Channels also did not get any evidence to prove it as a gay party.

It is not always the organization or groups want to handle issues legally. As far as possible all efforts were made so that the issue gets resolved in an amicable way. In many cases, active advocacy work from the community group (constantly engaging with people, appraising them of the situation of people infected/affected, giving correct information, rendering desired help and support) yield desired results of reducing stigma and discrimination as seen in the following cases:

- 13 year old boy on ART did not have money to visit the Government medical college to collect his medicines. The community members sensitized the teachers and requested them to lend help.
- “Public disclosure about HIV status” can be a powerful tool for galvanizing the community to support people living with HIV. In one meeting when discussion revolved around acceptance of PLHIV, a man stood and said “everybody talks about acceptance but I have actually done it”. I know my brother’s status and have accepted it” Hearing that villagers vowed to support him and any other person infected or affected.
- Stigma within family is significantly linked with stigma in the community, since many of the family actions are influenced by perceptions of community. In one case a family decided to keep the HIV status of its member within themselves and did not allow that person with any outside interaction or treatment. When the family member died as per community perception the family decided not to give him honourable burial, but the community workers helped family to understand and helped them to challenge the community’s perception.
- Team of staff and community members took on the responsibility of sensitizing around 240 government officials at the district level as part of a government sponsored activity over 8 days. This has resulted in increased referrals from various government departments, support from other departments in relation to claiming social entitlements and respect for community members as trainers.

Result 3: An effective institutional and legislative environment for reducing stigma and discrimination against marginalised and vulnerable groups.

3.1 Capacity building of healthcare personnel in order to improve quality of services along a continuum of care at government, private and community facilities for HIV and AIDS prevention, treatment delivery, care and support

Under this activity the project trained 1436 health care providers in the project areas to sensitize them around the issues of stigma and discrimination particularly with respect to sexuality and HIV epidemic. Initially, it was planned to sensitize doctors, nurses, lab technicians etc. But, the real problems that hit hard was taking these people out of their duties from the settings which was already grossly understaffed. This motivated partner organizations to train peer counsellors who would share the burden of staff and would be available to answer all the questions of HIV positive who walks in to ART centre. By placing additional hand lessened the burden of the staff. Also, different partner organization modified the activity in such a way based on their observations made during their visit to ICTC and also from the sharing of people who access the centres for various services. HIV positive person does not get to talk to anybody at the ART centre, due to heavy rush, congested place, indifference of personnel, preoccupation with filling OP slips, non cooperation and non-coordination from other
departments. Hence, the training was handled at two levels. Each organization trained several people living with HIV and their caregivers on ongoing basis on early diagnosis of OIs, adherence to treatment, initiating and sustaining lifestyle changes, nutrition enhancement, managing stress and resilience building. Many people trained are actively involved in providing information and support in the community care centres. They accompany the people who are referred, take care when they are admitted, take care of children when they are admitted, loss of fear leading to handling of the person after death, performance of last rites, emotional support during crisis or encouragement for adherence through personal testimonies.

At another level nurses, lab technicians and counsellors are trained on an ongoing basis, both from ICTCs and ART centres. In addition, INP + affiliated partners in the district closely work with government hospitals. Some centres, planned to train students of medical and nursing colleges so that when they practice their profession they would have clear understanding. In semi urban centres the local private practitioner including homoeopathists were given training on basics of HIV/AIDS and educating them the various referral services available. The PHC staffs were also given training regarding administration of Nevirapine, regarding usage of disposable gloves, keeping colour coded bins for wastage disposal etc. All this greatly reduced the fear in the minds of healthcare personnel regarding HIV. It was also actively advocated with authorities to supply the consumables to PHC.

Apart from the local trainings combined trainings were organized by INP+ for the project staff, namely project officer, counsellor and outreach staff regarding treatment updates, adherence, side effects etc which equipped them well in giving right information to clients and also in the hospital.

3.2 Monitoring availability and quality of treatment at government hospitals; and adherence to universal precautions and to protocols for post exposure prophylaxis.

The project staff regularly visited the ICTC, ART and RCH centre. Most of the time outreach staff was available in the ART centre or other related services. This method not only gave comfort to the client emotionally, it also provided support to the ART staff as they complemented and supported each other. They also regularly collected information on availability of ART/UP/PEP. Periodical exit interviews were taken from the clients almost all centres and both the areas where clients are happy as well as areas which need improvement are shared in the appropriate forums. The updates are given to the District Project Manager who reports to SACS. Some members were part of CST team (Care, Support and Treatment) during review meetings at district level. All the problems related to ART and allied services are brought up for discussion like non availability of CD4 machine, delay in operating the machine, collecting bribe at ART centre to jump the queue or reasons for loss of follow up on ART etc. In spite of the fact that project staff closely working with ART and allied services, certain limitations continue to date like Breach of confidentiality at the ART centre unfriendly behaviour of medical doctors at few ART centres, ill behaviour of the staff, lack of CD4 machine, incompetence of particularly lab technician etc. All this resulted in repeated visits to hospitals by client which in turn meant loss of wages, loss of time etc. It is also seen that representatives from positive networks also do not want to take up issues for the fear of causing displeasure with the hospital administration. It is seen that whole health care is target oriented which does not do good to anyone. Health programmes need to be integrated within the primary health care system with decentralized planning, decision making and implementation with active participation of the community. So as per decentralized plan DAPCU has been established on papers, it is not fully functional in its form and content. Hence, we expect that once that is initiated fully the services at the ART centres would be more patient friendly. However, some of the partners who receive funds from state reported that there is rampant corruption at the district levels and if any NGO/CBO do not co-opt then they are marginalized. Also, registering destitute women for ART services poses a big challenge.

Through constant advocacy some agencies have been successful in making positive women access reproductive services for abortion and sterilization.

Result 4: Effective functioning of an umbrella organization, established with the objective to build capacity of coalition members to cooperate and manage future projects in the area.

4.1 Establishment, formalization and operationalization of an umbrella organization of coalition members to build capacity and manage future projects in the area.

The informal group of members met for the first time in 2003 and shared various concerns regarding different issues around the epidemic which included entrance of new big donors without community perspective. Each of the organization in the group, whether small or big were working in the field of HIV/AIDS with marginalized groups for several years. Hence the group was a combination of CBOs
and NGOs. Before entering into formal agreement at the project start, detailed study was done by an external consultant who assessed both strengths and weaknesses of each organization and how each member can enter into symbiotic relationship. Keeping in view the individual partners capacities, goals and vision a proposal for action was drawn. The coalition decided that SIAAP would be the lead agency for the action. Both the project coordinator and accounts team would report to the Programme Director, SIAAP.

Once the project started the first thing was to formalize the group of coalition members. Based on the donor contract, another contract was formally drawn between SIAAP and seven organizations in the coalition.

All the activities of the functioning of the umbrella organization were done as per plan. The PMC met at regular intervals as laid in the policy. The date of the meeting was fixed in consultation with all the members. The agenda of the meeting was drawn well in advance and circulated for any additions. After the commencement of this project PMC met 14 times. The meetings were held at various partner organizations. This helped the partners in the consortium to understand the work of others. At the beginning of the project PMC met and framed both PMC policy document which had various guidelines regarding number of times PMC would meet, the governing members, and their, roles and responsibilities, etc.

When the coalition was only a few months old there was tension that employee from one coalition organization was offered a better salary to join another partner organization. Immediately the PMC was convened and “code of conduct” was carefully drawn so that the tension which may arise among organizations in coalition is minimized.

Both these documents were followed religiously particularly by the lead agency and whenever in doubt about the functioning these documents were referred. Many of the PMC members are respected nationally and internationally and were invited to participate regularly in various high level meetings, which were shared at the PMC meetings. The key discussions during the meetings revolved around the project deliverables, ways and means to improve the performance and bring maximum impact. The challenges faced with in the communities/ or in dealing with local government authorities were also taken up. The reports received after each of the visits either from EU delegation or other monitoring visits or external evaluation was discussed threadbare and strategies drawn to improve the working. There is also a periodical update from the lead partner regarding the status of the result areas vis-à-vis budgets.

The project coordinator minutes the meeting proceeding, circulated the same to all members for their feedback. Based on the discussions the coordinator would draw the follow up actions and circulate to all.

To quote the external evaluator “PMC has conducted itself with dignity despite facing some very challenging issues of coalition. Some of the PMC representatives are person of extraordinary skill, commitment and repute and have years of experience in governance and management issues”

In the middle of the project period conflict situation arose in which three members were involved. The conflict came up because the positives identified from the centre wanted to be part of another group which was not under DLNW. This caused tension among partners and the issue was time and again brought to the PMC for discussions. Finally, PMC agreed on the following:

- Need to spell out the issues clearly before attempting to resolve them
- Main reason for conflict being issues of parallel networks
- Role of INP+ to strengthen networks and relationships
  - District networks; issue of identities and power dynamics
  - District networks to see larger picture at district level.
  - One group cannot meet aspirations of all groups
- Chief reasons being the constituencies are different and there needs to be some flexibility.

The above discussion resulted in the following questions, which mediation answered.

1. How do individual coalition members help Positive people at local levels to work together within the INP+ structure
2. What is the role of INP+ within the coalition and how should different members relate with INP+?
3. How can INP+ find other ways of including positive people / groups at local levels?
4. What are the mechanisms (who/when/what/where) for resolving conflicts between members?
5. How is the issue of parallel networks to be addressed?
6. What are mechanisms to increase trust and solidarity among members?
The mediation was done by an external mediator Dr. Amar Jesani and his findings were shared and the partners agreed for coexistence of groups.

Apart from all these regular activities which are part of functioning of the project, PMC additionally met to understand the key components of NACPIII and its implementation, to learn more about the contents of the HIV/AIDS Bill and why it is pending.

PMC also actively participated in the three day external evaluation in April 2009. The whole process was participatory; and the members reflected upon their strengths and weaknesses.

The diversity of language, geography and identities posed difficulties in coming together as a legal organization with a common identity. However, what has been seen is they can come together on a common platform of shared issues for advocacy. Different members of the consortium can come together for different national issues, but connect with other CBOs in their own geographical area for local issues. The legal registration was not seen as an advantage by the partners. The consortium is not formally registered.

4.2 Facilitating government and private agencies to replicate CVCTC+ and to mobilize self help groups of communities

As partners in the consortium worked with different vulnerable groups each tried to understand the other vulnerable group’s members situation and problems. Community and CVCTC+ team understands the meaning of community leadership and advocacy, responsibilities of a person doing advocacy, types of advocacy. It promoted the concept of self help and worked around the advocacy areas of health, education, social security, woman and child rights related issues. Though it could not fully achieve in its objective of replicating the CVCTC+, it has shown the importance of community participation in ICTC and ART centres, by demonstrating their support and helping them in their work. Some communities were involved in running services under GFATM. Positive group Sadhane has already influenced government agencies like NACO which has awarded them intervention project. CVCTC+ is also actively involved with district governance and worked actively helping members claim their rights and social entitlements.

4.3 Identifying required changes and taking action on policies that will facilitate future work of coalition members in this area.

INP+ jointly with Lawyer’s Collective organized several programs/campaigns in support of HIV Bill to be tabled in parliament. All coalition partners signed the campaign and listed out the gaps. Sarvojana was also part of Tamil Nadu Steering committee and submitted memorandum to Dr. Anbumani Ramadoss (ex-health minister) regarding early tabling of HIV bill in the parliament.

At the national level one of the coalition partners was a member of INFOSEM a national network of sexual minorities. INFOSEM developed a document “Evidence to Action”. This was submitted to NACO as part of advocacy strategy for scaling up of TIs among MSM and TG under NACPIII. The notable thing was this became the basis for operational guidelines. The guide lines included key elements like consistent condom usage, number of partners in one month, health seeking behaviour of the community and percentage of penetrative anal sex being practiced in the community.

2.2. What is your assessment of the results of the Action?

Introduction:
The assessments of the results of the action in respect of most of the areas have been extremely good. The project has been reporting annually based on the log frame indicators. Both internal and mid-term evaluation reported achievement in many of the indicators.

At the end of the project period, it is interesting to measure the results against the expected results and activities in the Logframe and analyzing and assessing how much of overall and specific objectives of the project have been achieved. This section covers the results, measured in terms of percentage, contributions of such results towards fulfilment of objectives and the impact narrated by the community members in their own words, shared during various forums/workshops/meetings during the last year of the project.

As per the revised targets, the CVCTC+ along with INP+ should facilitate in the process of marginalized communities that are disproportionately affected by HIV/AIDS (7000 PSW, 20000 GBT, 15000 PLHIV and 50000 PIE) to have equitable and better access to high quality treatment, care and support, leading to improved quality of life.
1.1 Seven (7) replicable models of CVCTC+ established and operational across project areas
Outcome: 100% achievement
As stated under Sec 2.1, all 7 centres were established and were providing the basic services like
counselling, testing, medical and referral services. In addition the centre was also fulfilling the felt
needs of the community. The service uptake was slow in the initial years, timely interventions and
consultations with the communities helped to make necessary changes in the functioning of CVCTC+s
in order to make the centre congenial and sensitive to the needs of the communities. Two centres set
up a beauty parlor for women to avail services at subsidized rates, set up a phone booth to avoid
making private calls in public, etc. Generally, in all places the centre was hub of community and it had
vibrant energy. It was locally known to all in the area. The centre coordinated and worked with the
organizations in the same geographical area who worked with similar communities.

The centres were established with the intention of replication. When the project was conceived in 2005
there were not many VCT centres in the government health care settings. However, under NACP III
there was massive upscale. Hence, the community based centres could not be replicated. However,
the CVCTC+ established under this project were recognized by the governments and the data
emerging were fed into the state MIS. The unique aspects of CVCTC+ like community friendly
environment was created to a limited extent in the government run VCTC and in ART centres by
placing our community staff and demonstrating to the staff of VCTC.

1.2 45% of target group (41,400) report use of CVCTC+ services
Outcome: More than 100% achievement
At the end of 4 years, the CVCTC+ services had reached 348441. As against the target of 41400 it has
almost reached more than 8 folds

1.3 70% PLHIV (10500) in project areas seeks early diagnosis and treatment for Ols.
Outcome: 33% in respect of base figure of 10500 (which is 70% of 15000) as given in the log
frame. However all positive clients identified in the four years from the 7 centres, along with the
referrals made by INP+ in their project areas, 2931 clients were referred for ART centres and were
taking treatments for Ols.

The CVCTC+s have played a key role in shifting the attitude of people with regard to testing from, “...
God has brought me to this world let me enjoy my life … I will be inviting a problem if I test for HIV… it
would be better to die without knowing that I have HIV, than dying knowingly…” to
“People had half knowledge, lot of misconceptions; had no information where to go. CVCTC+ has done
a good job by opening centre in our area and giving all necessary information to get rid of our fears and
doubts”.

One client who visited CVCTC+ shared that “he was so happy to see the treatment and kindness
shown by the centre towards positive people, in contrast to people who were very unkind that gave me
courage and confidence to live.”

A client left his family for good and came to CVCTC+ for castration. The counsellor spent lot of time
with him explaining both the pros and cons of the issue. The family members also came to the centre
who were also counselled and were given information on sexuality and sexual preferences. After
several sessions and also hearing from the sharing of people who have got castrated, the client
decided against it. His family also has accepted him back and supports him.

One female sex worker shared that “nowhere else we are treated with respect and dignity as in here.
Once inside the centre we feel as humans and staff and other members alike even sit with us and
share food with us.”

1.4 After year one, 3000 people seeking CVCTC+ services and 100% yearly increase thereafter.
Outcome: 98% achievement
As against the target of 45000 clients to seek services at CVCTC+ at the end of four years, a total of
44219 clients had accessed CVCTC+. At the end of year 1, there were only 1131 clients (against 3000),
the access to CVCTC+ increased to 10946 in the second year and reached peak in the third
year touching all time high of 16711 and their after it platitude. In the last year 15431 clients had
accessed services at CVCTC+. On the whole, 44219 clients accessed CVCTC+ services in the four
years accounting for 98% achievement against the target. The reason for the dip in the fourth year is
people were consciously motivated to access government health care as that would be sustainable option beyond 2009.

1.5 60% of people tested sero-positive are receiving social support
Outcome: More than 100%
Out of 17688 clients tested in 7 CVCTC+ in the four years, 1587 clients tested positive. There were also direct walk in clients who were tested positive elsewhere and came to the CVCTC+ to avail for appropriate care and support, which included Support Group Meetings, receiving nutrition supplements, referrals to ART Centres etc. In addition, INP+ also referred their network members to various services based on their need. So there was more number of referrals made than the number of clients tested positive in the CVCTC+.

The impact of social support rendered can be seen from the following sharing:
1. 35 years old female regularly visiting the CVCTC+ was imparted nutrition counselling. Due to her motivation, her CD4 raised from 157 to 528 as she realized the importance of having nutritious food along with ART.
2. 28 year old female shared in support group meeting that she has to get admitted in hospital for treatment, but she has no support from family and also she would not be able to earn any money for those number of days. The group discussion made her realize that how important is to get treatment. The group members encouraged her to take decision and promised to take care of her child and also contributed some amount to compensate for her loss of wages. In the next meeting she thanked all the members who made it possible for her to take treatment.
3. HIV positive women were helped to get Rs.10000/- from government and also helped them to get pension every month.
4. A female sex worker who was positive came and collapsed in the centre. The team rushed her to nearby ART centre where her CD4 was just 37. She was asked to be admitted immediately. Since, there was no attendant; CVCTC+ staff helped her to get admitted into a care centre where she recovered.

Result 2: There is an improved quality of services for care, treatment and support for marginalized and vulnerable groups.

2.1 A minimum of 50% of the target group members identified positive receive adequate care at accessing Government hospitals in the project areas.
Outcome: 100 % for ART and allied services.
As stated above, 2931 clients were referred to ART centres in the Government hospitals and all of them were enrolled in pre-ART services. All of them underwent baseline investigations and eligible people were initiated ART.
Since the project staff had good rapport with the Government hospitals and extended their support at all possible times, the clients referred from the CVCTC+ were treated with special care. In the words of a female positive client, “... if we go through CVCTC+, we get good response from health care providers... respect and confidentiality is also assured...” Similarly many clients had shared positive feedback about the services at the ART centres. It was further ensured through exit interviews and discussions at Support Group Meetings that there was no discrimination or sub standard treatment for clients from CVCTC+.
It is also a fact that the project has influenced staff from the Government health facility to render stigma free services. A member from a positive network shared, ”... In our area, CVCTC+ has helped many people to access early services without any fear, stigma and discrimination. It has saved many people’s life, money and relationships”
Placement of peer counsellors from CVCTC+ has encouraged the people to access government health care without hesitation. As one client shared “Seeing X in ART centre I am greatly relieved” Also, peer counsellors shared that “ART counsellor watch us how we talk, listen, hold clients hand, make them sit, offer water etc” Slowly they also try and behave with the client in a similar way.
5 out of 7 centres were recognized by respective SACS as ICTC and data flowing out of them were fed directly in to the state statistics. Many ICTC staff visited CVCTC+ and understood the settings that existed in the CVCTC+ and tried to adopt the same which helped community.

2.2 At least one ARV treatment service centre (including monitoring CD4 count, Viral load toxicity testing facilities) in a Govt hospital in each project area, accessible to target community providing quality psycho social support.
Outcome: 100%
Though there were not ART centres at all the project areas on the start of the project, this result was achieved essentially due to scaling up of ICTC/ART during second phase of NACP. At the end of the project period many areas had more than one ART centre. As far as the quality of service at the ART centre still remains a concern which has been detailed under Sec 2.1.

2.3 There is an adequate supply of ART drugs in ART Centres
Outcome: 100%
Though there were not ART centres at all the project areas on the start of the project, this result was achieved essentially due to scaling up of ICTC/ART during second phase of NACP. At the end of the project period many areas had more than one ART centre. As far as the quality of service at the ART centre still remains a concern which has been detailed under Sec 2.1. The project staff monitored adequate supply of ART Drugs in the ART Centres in the project areas. It involved personal visit to ART Centres, interaction with ART Counsellor. Exit interviews were also conducted periodically to assess the quality of service and the deficiency in the services were reported and openly discussed in the district forums. The quality of service was also assessed regularly by initiating discussions at the support group meeting.

2.4 At least 35 people have been properly trained for providing services at the community care centres.
Outcome: More than 100%
Several community people and care givers were trained They in turn are actively involved in the community care centres and ART centres.

Each of the 7 centres trained 5 members each on early diagnosis, identification of OIs, treatment education, positive living. In addition 24 people took community counselling training, 20 took treatment adherence, and 50 took legal training. Additionally, the positive groups formed at the centres and networks under INP+ did specified trainings on economic empowerment, importance of nutrition and treatment adherence.

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<tr>
<th>Result 3: An effective institutional and legislative environment for reducing stigma and discrimination against marginalized and vulnerable groups.</th>
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3.1 A functional consortium of civil society organizations working to reduce stigma and discrimination and increase equitable access to HIV and AIDS services for the target groups. Alliance with Lawyers collective and other legal bodies supporting the Bill pending introduction in Parliament and seeking their support in instances of stigma and discrimination and inequitable access of treatment services
Outcome: One functional consortium in place.
The main focus of the consortium is to reduce stigma and discrimination. INP+ jointly with lawyer’s collective organized several programs/campaigns in support of HIV Bill to be tabled in parliament. All coalition partners have signed the campaign and have listed out the gaps. Sarvojana was also part of Tamil Nadu Steering committee. Lawyers Collective is also conducting training to the community on an ongoing basis. The community gets specifically trained DV act, property rights, and sexual harassment at work place and fighting legally against discrimination.
At the national level one of the coalition partners was a member of INFOSM a national network of sexual minorities. INFOSM developed a document “Evidence to Action”. This was submitted to NACO as part of advocacy strategy for scaling up of TIs among MSM and TG under NACP III. The notable thing was this became the basis for operational guidelines. The guidelines developed by Humsafar Trust to determine High risk behaviour which included key elements like percentage of consistent condom usage, number of partners in one month, health seeking behaviour of the community and percentage of penetrative anal sex being practiced in the community were accepted/adopted.
Some of the partners work closely with CFAR an organization working with media and Lawyers Collective. CFAR has helped community to address media openly and also provided technical support in drafting press release and writing articles. Due this more than 10 positive community members from one centre are addressing the media, public and other stakeholders as positive speakers.
Every year NACO conducts sentinel Surveillance in India. Random blood Samples are collected and tested. The HIV prevalence rate is gauged out of 250 samples from MSM community and tested. In the year 2008 the sentinel survey was done and the HIV prevalence among the MSM community was 19%. 

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NACO/KSAPS have recognized Sangama CVCTC+ as an HRG centre. Every year, there will be a sentinel survey conducted for the community. For this, the lab technicians were given 4 day training at NIMHANS. KSAPS provided all the materials for the survey to CVCTC+.

**Working with DAPCU and SACS**

In all districts where DAPCU is established, a meeting is held once in a month. Community at CVCTC+ actively participated in the meeting regularly. In these meetings sharing of reports, issues related to Govt. health care providers, ART centre and linkages are discussed. Due to the active involvement of DAPCU the incidences of discrimination has tremendously decreased. This process has strengthened the Govt. ICTC services and has helped the community at a larger level. CVCTC+ staff built a good rapport with the Govt. ICTC staff which has supported the community to access services from these health setups.

In spite of the fact that the partner organizations were working closely with different agencies, they handled cases of stigma and discrimination individually. There is a need to develop a mechanism through which cases are identified and classified in to different categories and plan for a collective action.

3.2 An effective alliance of 16 groups of target communities of PSW, GBT, PLHIV and coalition members engaged in community mobilization and advocacy at Government, health care providers, private medical practitioners, police department and community levels to reduce stigma and discrimination

**Outcome:** 30 groups big and small were formed at different CVCTC+ during the project period.

Every CVCTC+ encouraged formation of both community groups as well as groups of positive people. At the end of the project period there were 6 positive groups with 1861 members, 15 MSM/TG group with 2578 members and 9 PIE groups with membership of 110. One CVCTC+ did not form any group, rather they preferred to strengthen already formed women’s positive group. WSW from the centre was integrated with the existing CBO under which centre was established.

All groups effectively took up advocacy activities with government, private health care providers, police department and among the general community to reduce the instances of stigma and discrimination. Whenever, any major issue had to be handled, they joined hands with coalition partners who were either CBOs or community based NGOs.

Though two meetings were held jointly which gave the groups a forum to interact, discuss and identify issues it cannot be called an effective alliance as groups came from different geographical locations, speaking different languages, different cultural background did not contribute towards fostering of these groups.

3.3 Government policy in place in project areas to support equitable access to HIV and AIDS prevention, treatment delivery, care and support services and act against routine arrests, violence and termination of employment, policy support for health and life insurance and for equitable care services for PSW, GBT, PLHIV communities

In most of the places there is no separate policy available. However the activities of the Government like scaling up number of centres during NACPII indicate initiative taken by the government for the supporting HIV/AIDS prevention, treatment delivery, care and support. Also, most of the PHC have started counselling and testing. Due to active advocacy the PHC has started conducting deliveries for positive women.

There have been no problems related to ART access. The district positive network that was strengthened by the CVCTC+ continues to advocate for any service gaps at the service sites.

**Result 4:** Effective functioning of umbrella organization, established with the objective to build capacity of coalition members to cooperate and manage future projects in the area.

4.1 Consortium of community institutions and CSOs formally registered.

Consortium of community institutions and CSOs have been formed. They have met regularly as per the policy guidelines and procedures. Each member in the consortium had different strength and all the inputs were effectively used for the project implementation. The consortium is not formally registered as an organization. Detailed discussion regarding registration of consortium was taken up at the May 2009 PMC meeting. There was divided opinion as to whether any formal structure should be given to consortium. Though it is one of the project deliverables, members discussed both advantages and disadvantages formalizing which included cost of maintaining secretariat, accounting, legal obligations, getting approval from individual organization from their respective boards. Coalition members have been interacting with each other and learning from each other: “It has not been a formal group but a
group based on friendship and growing respect", its collective voice is much stronger and it was acknowledged that mutual support was necessary.

The need for a proper structure to govern the coalition, the need for formal leadership was discussed at length at the PMC meetings. It was recognized that to formalize this structure, it was necessary to refer to each state law across five states. Moreover, any legal step towards this would involve individual approval from the Board of each member organization. It was decided in the PMC that the coalition would continue in its present form and continue to function as the “keeper of conscience for all of its members.” There was also discussion about entry/exit criteria for members.

As pointed out in the evaluation there were not enough tools and indicators to capture outcomes, in particular the project log frame, have not been adequate to capture the way the coalition works and its achievement. However, it has been captured well in the external evaluation document on the following domains based on the stories which was shared by the participant:

- Ways of working together with respect and dignity.
- Shared learning and mutual respect.
- Giving voice and agency to community: How the insights of an illiterate HIV infected widow when supported by a member organisation became the basis of an attendant care programme for income poor and altruism rich women
- Advocating issues of marginalised communities: The action campaign developed nationally and in Tamil Nadu to create awareness about the draft HIV bill which guarantees the legal right of people living with HIV marginalised communities across India.
- Creating spaces of diversity and courage in action
- Politics and ethics of HIV work: The lead role of coalition member in preparation of a national advocacy strategy and preparing a document for sexual minorities titled “Evidence to Action” which was adopted in the operational guidelines for MSM/TG.

The detailed outcomes are shared in the attached evaluation report. These domains were considered to reflect the vision of the coalition and to capture the purpose for which the member organizations came together. The evaluation report page 50-55 captures this area in entirety.

**4.2 80 % (12) of the community networks/institutions promoted by the project have local office bearers and a board which manage programmes independently.**

**Outcome: More than 100 %**

Out of the 30 groups which were formed 13 groups have office bearers and a board which have the capacity to manage programmes independently. However, out of these 13 groups only 8 are registered under various State Acts. The capacity has been built for all the members and board to handle the programmes independently. During the tenure of the project they were given specific trainings on organizational development, leadership development, proposal writing, project implementation, conflict resolution etc.

One organization particularly working with women in sex work faced lot of challenges in promoting a community group. The organization had a sufficient experience in successfully facilitating formation of community groups and nurturing them. But in spite of adopting tried and tested methods it was not successful. The reasons which were identified over a period of time were lack of leadership, members not willing to contribute even 2-3 hours of their time for growth of the group, members kept their individual problem ahead and came only when they had problems. They did not appreciate activities to prevent the problems. They were all very active sex workers and earning money was their key most priority and in a nutshell did not want to invest their time and energy towards group activities. However, few members (15-20) who still wanted to be part of some CBO where integrated with the already existing CBO.

**4.3 50 % (8) of the community groups promoted by the project network, work jointly with other community groups on issues of mutual interest.**

**Outcome: More than 100 %**

The community groups formed by the project network first work with the coalition member. In this project the coalition member also being a CBO they collaborate at the coalition level to take ahead the issues like HIV Bill. Again in the case of positive people the group members are also members of DLNW where the issues are taken up in a corroborative manner.
<table>
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<tr>
<th>Result</th>
<th>Objective</th>
<th>Outcomes</th>
<th>Challenges</th>
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</table>
| 1      | Improved quality of life of PSW, GBT, PLHA, and WRE through improved health seeking behaviour at Community based Voluntary Counselling, Testing, Support and Care Centres (CVCTC+), and through increased assertion of rights for equitable HIV & AIDS prevention, treatment delivery, care and support services. | • All 7 CVCTC+ were functional till December 2009  
• A total of 348441 clients were reached through Out reach work  
• 44219 clients accessed services at CVCTC+  
• Out of the 44219 clients visiting centre, 17688 clients were tested for HIV and 1587 clients were identified positive  
• There were appropriate referrals made for all the 1587 positive clients identified in the CVCTC+ along with the direct walk in clients (tested positive elsewhere) and those referred from the networks  
• Accordingly, 2931 clients were referred to ART centres, 3898 clients were referred for OI treatment, 3053 clients were referred for STI & RTI treatment and 1236 clients were referred for DOTS treatment and 7997 clients were treated for general illness. | 1. Follow up of cases becomes difficult as people do not disclose their correct address and also shift places to seek employment or to get emotional support.  
2. Though the partner notification in MSM/TG community has improved to a great extent still it is a barrier.  
3. MSM/TG community still seek help from unprofessional hands for Castration. |
| 2      | There is an improved quality of Services for care, treatment and support for marginalised and vulnerable groups. | • All the clients referred to ART Centres were enrolled in pre-ART services. After the baseline investigations, the eligible clients were initiated on ART.  
• Due to upscale of ART Centres, there are more than one ART Centre available in some project areas  
• There was adequate supply of ART drugs which was constantly monitored through client exit interviews and sharing during the support group meetings  
• More than 35 community people (both staff and volunteers) were trained on various topics such as Counselling, Treatment Education, ART Adherence, Identification of OIs, etc. | 1. Confidentiality is the major issue at ART centre.  
2. Attitude of the staff at ART is not friendly at times, which results in permanent loss of client. |
| 3      | An effective institutional and legislative environment for reducing stigma and discrimination against marginalised and vulnerable groups. | • One functional consortium in place ensuring stigma free services for people from the vulnerable groups.  
• INP+ initiated to table the HIV Bill along with Lawyer’s Collective. All the Coalition partners have signed the campaign and also have listed the Gaps in the Bill.  
• Lawyer’s Collective also conducted training program for community leaders on | 1. Few members in positive groups tend to dominate as a result benefits do not percolate to all members.  
2. Community groups require lot of handholding and motivation to take up issues  
3. Though the district level networks have woman and sexual minorities on board but they do not come forward to take responsibilities due to cultural and social barriers. |
<table>
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<tr>
<th>4</th>
<th>Effective functioning of an umbrella organisation, established with the objective to build capacity of coalition members to cooperate and manage future projects in this area.</th>
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<tbody>
<tr>
<td></td>
<td>• Although the consortium was not registered as an organisation, they met regularly and synergized their different strengths.</td>
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<tr>
<td></td>
<td>• Although there were not any indicators under the result, it was highlighted in the external evaluation that there was respect among the partners, that there was shared learning and mutual respect both among the partners and among the communities they work for.</td>
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<tr>
<td></td>
<td>• It was also highlighted that they gave voice and agency for the community and advocated for the marginalized communities.</td>
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<td></td>
<td>• Out of the 30 groups, 13 groups have office bearers and out the 13 groups, 8 were registered under the various State Acts.</td>
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<tr>
<td></td>
<td>• These community groups formed, primarily worked with the coalition member and the members of the positive groups are also the member of the respective District Networks, which takes the necessary action.</td>
</tr>
<tr>
<td>1.</td>
<td>Lot of energy expended in following up monthly technical &amp; Financial reports</td>
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<tr>
<td>2.</td>
<td>Lack of response from partners on important issues.</td>
</tr>
<tr>
<td>3.</td>
<td>Most of the partners are known nationally and internationally and hence have lot of commitments which gives them only little time towards coalition building.</td>
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</tbody>
</table>
2.3. What has been the outcome on both the final beneficiaries &/or target group (if different) and the situation in the target country or target region which the Action addressed?

In all the target regions where the CVCTC+ were established, focus was community involvement, community empowerment and strengthening the groups, who are the final beneficiaries. To achieve these goals the community was taken through series of trainings, exposure visits, hand holding and constant interaction and guidance. All this resulted in formation of strong community groups. The common benefits which were seen across the board are as follows:

**Community involvement and ownership:**
- Involving the target group in setting up the centre. They felt important when suggestions were taken for the CVCTC+, services required, etc. They also actively helped in resource mapping.
- They were also involved in deciding the number of outreach workers to be appointed for the project, helped in identifying outreach staff and fixed criteria for selection. They facilitated the process of interview and select suitable candidate for doing outreach work from the community.
- Since there was community involvement right from the beginning, there was good ownership. They showed interest in reviewing the outreach work done and gave contacts of peers and at times accompanied them to the field to improve service uptake. **They learnt how to conduct a recruitment process and how to monitor field work.**
- The community suggested to establish information centre in few key villages, also identified places for condom outlets, supervised the stock of condoms in those outlets from time to time. The community in general had a deeper understanding of the layers in different issues, had better insight into their rights and entitlements which facilitated in demanding services from care providers.

**Increased knowledge about HIV/AIDS for both community and PIE**
All organizations in general worked with PIE but particularly two organizations intensely worked only with PIE and PLHIV. Through village education process, building voluntary base, getting Panchayat to pass resolution against stigma and discrimination faced by PLHIV lead to friendly atmosphere for PLHIV and increased self risk perception among general community. The community attitude before the intervention was, “HIV is dreaded disease, positive people are burden to earth, we should keep them away from village, it is curse from the god for people who are indulging in pre/extramartial sex”. The same community changed its mind in the four years and shared that, “Agency has done a good job in opening CVCTC+ in our area because people had either half knowledge or lot of misconceptions, so we were also left with little or no information on where to refer people, CVCTC+ is very useful and needful at this point of time”.

**Reduced stigma and discrimination in health care settings and Support to PLHIV – Samraksha and WINS**
There was sufficient reduction in stigma and discrimination faced particularly by the positive people. In the exit interviews they reported about change in attitude of doctor, counsellor etc. Also support group meetings were held on a monthly basis in all CVCTC+. It started as a small group but membership increased continuously. The main objective was to provide social support by providing them time and place to ventilate their feelings and draw support within the group and to provide first hand information about ART and its importance. Initially the community counsellor facilitated, later the members from the group showed interest and took turns to convene the meetings. **This improved their leadership skills and helped them shed their self stigma.**

Support group meetings also paved way to monitor their CD4 status and the type of treatment given at the ART Centre. In the initial period there were instances when staff from other NGOs intruded and asked for the clients’ details such as address, phone number, etc. But over the project period, the staff from CVCTC+ built good rapport with the ART staff and explained the negative consequences of intrusion caused by the other NGOs and how it affects the privacy of the positive clients which result in poor follow up or unwillingness to visit ART. Due to frequent visits by CVCTC+ staff and the support they provided, the issue at ART centre was sorted out amicably. The community counsellor from the centre also visited the ART centre regularly and supported in peer counselling, which decreased the client load of the counsellor. The ART centre at the target region became more patient friendly and they respected the client’s privacy and confidentiality.
Another key benefit enjoyed by the support group members was nutrition supplement. Unlike other places, the members of the group decided what kind of nutrition they required. This gave good ownership and they referred many of their friends to test for HIV.

**Instances of support to PLHIV**

There were many instances when the CVCTC+ along with community or support group members intervened at appropriate times to provide support in all possible ways.

1. When a positive young widow living with her two daughters was forced to be evicted from her house by her in-laws, which was owned by her husband, the CVCTC+ staff joined hands with the CBO run by Women in sex work functioning in the locality and sensitized the people in the neighbourhood and gathered support. Simultaneously complaints were lodged with the SP, Theni, who took immediate action to stop eviction. **The solidarity of the Women CBO and the support from the local community helped the young woman to continue to live in the same house.**

2. During a support group meeting, one woman shared her difficulty in not being able to start on ART as it required to be admitted for 15 days initially which would affect her income, also there was no one to take care of her child. The support group members decided to contribute Rs.5 and pool Rs.300 and compensate her loss of income and volunteered to take care of her child. They insisted that she had to get admitted and start ART. She did as per their guidance and was initiated ART. Thus the support group meeting not only was a forum to discuss about their problems but also improved their treatment seeking behaviour. **As expressed by various groups at various situations, community people gather great amount of support from their peers. The support group meetings are yet another example to substantiate.**

3. Bridging the gap between people and the Government Departments were another commendable work taken up in many areas. There were many welfare schemes available for people and there were people who required them to manage their day to day living. The problem was documentation and procedures which accompanied. The people were helped in getting the necessary documents. CVCTC+ staff supported eligible people to avail these services through their guidance. There were many lobbying involved, where the status of PLHIV was at stake when they had to produce a certificate from the Tasildhar that they belonged to a particular location, in which their positive status was also mentioned. This had lead to involuntary disclosure and many feared discrimination and refrained from applying. In such situations, the clients were counselled and sensitized about the pros and cons of applying for the scheme. After the client was sensitized, the Government officials like Tasildhar, Village Administrative Officer, Panchayat President, Clerk, etc were met and sensitized about HIV and the major issues faced by PLHIV. More emphasis was given on respecting their confidentiality and the possible discrimination if confidentiality was broken. **This not only helped them to understand the condition of PLHIV, but also provided opportunities to support them. Similarly many young widows were motivated to avail widow pension. However, meagre the amount was, the women required them in order to meet their daily expenses. This not only supported them financially but they also gained more confidence about the centre.**

The networks had shared that the CVCTC+ has helped many people to access early services without any fear, stigma and discrimination and that it has saved many people’s life, money and relationships. Thus they have empowered PLHIV especially women, capacitated them through various trainings, advocated for their rights and sensitized the community through education meetings. During the project period it had also worked with Government and SACS and had paved way for stigma free treatment and support.

**Positive network members as beneficiaries- INP+**

The positive network members specially benefited from this project in the following ways:
- Capacitating PLHIV through trainings
- Regular support group meetings
- Pediatric support group meetings were held for the first time under this project.
- Media Advocacy on Gender and sexuality rights in Tamil Nadu and Kerala.
- Good governance and Organizational management workshop to capacitate people from 14 District Level Networks to help the functionaries of PLHIV Networks to carry out governance and management work more systematically and effectively.
- Leadership and management training was given to 28 newly elected district board members in order to develop a powerful second line leadership in the state.
- OI Management training was conducted to enable PLHIV to manage at times of infection.

FIRM took immediate legal action by filing petition to State and National Human rights commission on all cases of stigma and discrimination particularly to PLHIV.
To sum up the outcomes:

- Respect for human beings and friendship with the community members
- Condom, Impotency was, "taboo topics" that were brought out in the open for discussions.
- Initially SHG members were cynical about discussing health got interested after initiating conversation.
- PLHIV after visiting CVCTC+ requested the team to visit their homes and conducted awareness program in the villages to reduce fear and stigma around HIV.
- Nutrition support increased their man days, and reduced children’s morbidity

PSW and GBT in different regions

SIAAP, Theni

1. Increased Respect for Women Sex Workers and their rights:
   - An agency implementing TAI project in Theni providing reproductive health services had good rapport with the community. Community members were also very happy visiting that centre as they would get some incentive either in the form of cash or gift. Since CVCTC+ and their centre were located in the same area, coupled with incentive which they were used to receiving, it was challenging to mobilize Women to access CVCTC+ initially.
   - It continued to be a challenge until the mass testing of target people (WSW and MSM) in the District in December 2007. TAI tested WSW for HIV not only without consent but also without their knowledge that they were tested for HIV. The only information that was conveyed in the field was that ‘they were giving a Horlicks Bottle for a Blood test’. There was good response for the word of mouth campaign and many people stood in queue to give blood and collect Horlicks bottle. They were asked to sign a paper but did not know the purpose for which it was taken. There was no pre test counselling, no information that the test was done for HIV, no request for consent, no voluntariness and most importantly it was done with total disregard for the Rights of women. There was no post test counselling and results were given in the same manner. It was loudly announced to negative woman that ‘there is no problem in your blood. You can go’; whereas the positive clients were told, to come back two days later for additional test. There were lot of whispers and sarcastic remarks among the rest of the women standing in the queue regarding the result not being given to few. But some community members were really upset.
   - CVCTC+ staff along with the community was against this mass testing which was both against human rights and the protocols for testing laid by NACO. So the community and staff joined together to protest against this and stop it immediately. There was a quick survey done among people who were tested and details relating to consent, confidentiality, pre test information, post test, etc were collected, collated and submitted to PD, TANSACS, who ordered for stopping the mass testing for HIV immediately.

   **Thereon the CVCTC+ gained attention among Women in sex work and there was slow but steady uptake of services. There were more referrals and many new women visited centre to test and utilize other services.**

2. Police Violence
   - There was a strained relationship between the community and the Police personnel. Hence the women faced much harassment and discrimination. They were even restricted from free movement in and around the bus stand. As the Center staff had good rapport with the police people due to their frequent visits to the Police station, they were aware that there was a program run for the benefit of women sex workers. At this juncture, there was a search for a woman sex worker at the CVCTC+ in connection with a murder. The Project Officer had sent that woman along with a staff from the Centre. But as soon as the woman entered, she was harassed, beaten up and put behind bars for almost 13 days. Along with all the violence, she was also sexually abused and asked to run away from the station. In the meantime, the Centre staff, with the help of an advocate, took all possible steps to support the woman, right from writing letters to the Superintendent of Police till visiting her in the station.

   **Thus the women in Theni gathered more courage to face the police. They were also confident that the CVCTC+ was there to help them or come to their rescue at any time. This lead to getting cards printed containing information pertaining to health and contact numbers of centre staff to call at times of emergency.**

FIRM Kerala

- FIRM CVCTC+ provided stigma free services to their target groups which was evident through the increase in service uptake by clients. They not only tested people coming to their centres but also conducted Village Education programs and organized campaigns for testing in order to assess the prevalence. This process enabled FIRM to start ‘Friends’, a CBO of MSM.
FIRM trained 6 members from the community both theoretically and practically on various topics like Counselling, Ethics in HIV testing, Advocacy, Relevance of CBO and its formation, Basic knowledge about Sec. 377 and ITP Act, etc. in order to capacitate them to manage a CBO in the future.

FIRM had advocated with the DGP on the Rights of PSW and as a follow up of their actions, a circular was issued by the IG of Police, Mr. Senkumar, to all the Circle Inspectors in Kerala instructing them not to harass PSWs unlawfully. FIRM had filed a petition to know whether the Kerala Police was sensitized about the High Court Ruling on the legal position of PSWs, on a writ filed by FIRM, under the Right to Information Act. The Kerala Police have replied that the Police force in Kerala has been sensitized about the legal position of PSWs

Sangama Bangalore

Sangama CVCTC+ has become a Model ICTC enabling many MSM clients to voluntarily walk in for services. Through the CVCTC+ they not only tested for HIV, syphilis, blood grouping, but also established strong linkage with Government services in order to provide sustainable services. Their main goal was to bring about a change in the society and mainstreaming sexual minorities by greater acceptance by the society.

- People tested positive were referred to ART centre and were motivated to join the support group, ‘Sadhane’, which was later registered as a CBO. Sadhane has developed wide network with large number of care and support centers in and around Bangalore. The clients who required further treatment and support were referred to Seva Clinic, ACCEPT, Bowring hospital, Victoria hospital, Freedom Foundation, KIMS and Snehadhan etc. with whom they have established linkages keeping in mind about the sustainability of services for the community.

- Sangama CVCTC+ has also supported Sadhane members to develop skills to get self employed. Many of them were trained to prepare candles and toilet cleaning agents. The project has also encouraged, trained and invited experienced community people from Arunodaya network to train Sadhane members on PTE. Few skilled staffs from Sadhane and CVCTC+ were provided training to develop street play script towards reducing stigma and discrimination.

- The project also closely worked with CFAR an organization working with media and Lawyers Collective. CFAR has helped CVCTC+ as well as Sadhane to address media openly and also provided technical support in drafting press release and writing articles. Due this more than 10 positive community members from Sadhane were addressing the media.

- Through the Lawyers’ Collective the project staff and Sadhane members were trained on DV act, property rights, sexual harassment at work place and fighting legally against discrimination.

The Humsafar Trust(HST)Kalyan CVCTC+ Thane, Maharashtra

The MSM and TG community is highly stigmatized and discriminated in the society and particularly in health care settings, thus making access to health services difficult. CVCTC+ was very close with general public just as they were close with the community (WSW) and PLHIV. They were welcome to support any client who stepped in the centre with any problem. The project staffs were sensitive to receive clients and provide them time and space, listen to their problems and take appropriate decisions and make appropriate referrals. The CVCTC+ took additional efforts to establish linkage with many departments and they could comfortably refer people based on their needs. Such referrals include referring a hostel facility for a destitute PLHIV widow, who did sex work to earn money.

As the centre had good rapport with Police personnel, Health care providers, Government Officials, etc, CVCTC+ could render all possible support for people from communities like MSM, TG, WSW, PLHIV and PIE. It had build capacity of many women sex workers through trainings on condom negotiation, counselling, operation of computers, Spoken English, etc. The dignity of the women also increased when they were offered job at CVCTC+.

Community who were living miserably and did not have any mode of income for survival other than sex work and begging were the only option. That made them very vulnerable to acquire infections. Hence to enable them a source of income that shifts them from the infection was planned. Accordingly with the help of Social Welfare organization they were trained for Beautician, Computer, Mobile repair, English speaking, etc.

Good rapport with hospital doctors and counsellors helps in getting good support and reduces the instances of stigma and discrimination faced by the community. This also resulted in increase in the number of registrations in the ART centres in Mumbai and Thane District. Health camps attracted community members where medicines were provided by Rotary and Lions club.

The clinic board and banners attract attention and many people visiting the market show up at the CVCTC+ and they are given complete information about HIV and AIDS and other services. These have helped us in bringing mainstream populations into the clinic and sensitize them on the issues of the community and HIV.
Partner notification was the problem of the MSM community but this problem sorted our by giving them reference of FPAI clinic now community member sending there partners at FPAI clinic and trough that the confidentiality of the identification keep intact.

**SWAM Chennai**

SWAM also works with MSM, TG and double deckers. The target groups benefited quality counselling, reduced fear of testing, 24 hours crisis assistance etc. Among other things DDs were particularly benefited under this project as they were not covered under any other intervention and the stigma faced by them was more in government health care settings. Good quality counselling has resulted in change of behaviour in the area of castration. Also, the CVCTC+ provided care and support home for people who underwent castration, where good counselling and nutrition and clinical support were given. The aggressive sensitization of slum population resulted in the reduction of violence among kothis as most of the client’s of kothi stay in slums. CVCTC+ facilitated in the process of organizing 350 women in to SHG which lead to increased acceptance of MSM/TG community in the neighbourhood.

**2.4. Please list all publications (and no. of copies) produced during the Action on whatever format, amongst others containing new approaches, innovative ways of communicating… (please enclose a copy of each item, except if you have already done so in the past).**

**SIAAP**

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**Samraksha**

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**Samraksha**

01 - Auto Rickshaw for awareness program - 01
02 - Mike set - 01
03 - Banners on Information - 05

**INP+**

01 - Poster on ART adherence - 3000 copies
02 - Poster on “End discrimination - Support HIV Bill” – 500 copies
03 - CD on ART Adherence and Nutrition

**HST**

1. To know more about AIDS (English - 500, Hindi - 500, and Marathi - 500) – 1500
2. Stickers (English - 1000, Hindi - 1000 and Marathi - 1000) – 3000
3. Stickers (English - 1000, Hindi - 1000 and Marathi - 1500) - 3500

2.5. Please list all contracts (works, supplies, services) above 5000€ awarded for the implementation of the action since the last interim report if any or during the reporting period, giving for each contract the amount, the award procedure followed and the name of the contractor.

Not Applicable

2.6. Describe if the Action will continue after the support from the European Community has ended. Are there any follow up activities envisaged? What will ensure the sustainability of the Action?

The CVCTC+ was always conceived of as a vehicle to a larger advocacy and community building processes, rather than as a service delivery point. With that goal in mind, community groups have been sufficiently strengthened, are aware of their rights and entitlements and sufficiently empowered to take collective action with little guidance. Capacities of communities to effectively manage CBOs have been strengthened. One CBO which was registered in 2007 has been sanctioned projects from SACS and NACO for community interventions. The project aimed to bring about changes in the attitude of the health care personnel in the public sector towards marginalized groups, aid in early diagnosis and treatment, access to ART, as well as increase adherence to ART. This is also sustainable, mainly due to scaling up of ICTC/ART centres and further expansion of ART availability through link ART centres at the PHCs (district-level) under NACP II and III. Further capacities of communities to effectively provide services with respect to home care or community care centres have been strengthened. Similarly, the coalition will continue to meet periodically to discuss various issues that might require collective and concerted action. However, what has been experienced is that different members of the consortium can come together for different national issues, shared issues of advocacy and to share their expertise with other members whenever needed. **This solidarity could form the foundation for coming together on issues.**

As a follow up of the CVCTC+ experience, the coalition has started discussing the issue of accountability of various governmental and nongovernmental organizations. The coalition members felt that organizations working in the field of HIV/AIDS, especially those at the grassroots, experience grave difficulties in obtaining information, reports, data, as well as funding due to a lack of transparency and accountability. Sometimes, the issue is of procedural lapse and inefficiency. While organizations
Contribute to work at the grass-root level, oftentimes the most trying and challenging, they are not part of the information sharing network regarding the overall impact, numbers reached, benefits gained and cost-effectiveness or otherwise of such interventions. Information is obtained, or rather demanded from organizations as they are sometimes funded by the government, but, organizations have no way of demanding similar accountability from the government the goal of which is to improve programmes to benefit people. Also obtaining funds due to an organization and granted by the donor as per a formal written agreement through the government at the district level is a huge challenge as commissions and favours in cash are expected. Failure to comply with such expectations once again causes extreme hardship for that organization to continue to work in that district.

However, we detail below the sustainability plan of CVCTC+ by each partner organization.

Kalyan CVCTC+ (HST, Mumbai)
The centre has been taken over by MSACS. They are supporting for supply of HIV test kits and consumables, while HST pays the salaries of the counsellor and lab technician, but is hopeful that they will be able to negotiate with MSACS for that component too. All other activities of CVCTC+ have been made available to the community from the existing AVERT project and by July end all CVCTC+ activities will be included in the Global Fund Round 9 project.

SWAM
All the key components of CVCTC+ like counselling, support group meetings, and, to a limited extent, sensitizing people living in slums will be done through another project supported by UNDP. All the trained and skilled project staffs have been absorbed into that project so that the organization does not lose trained and experienced human resources. However, for purposes of HIV testing, clients are referred to government hospitals.

Sangama
Sangama CVCTC+ has motivated ‘Sadhane’ to play an active role in the referral services to sustain the link between the CVCTC+, Sadhane and Government health care providers. During the project period, CVCTC+ guided Sadhane group leaders to engage with civil societies, human rights organization, HIV forums, legal forums and progressive movements to fight against stigma and discrimination and to enhance support for the PLHIV rights struggle. In order to increase health seeking behaviour among PLHIV, Sadhane built linkages with service providers for appropriate care and support. During the tenure of the project, Sadhane was commissioned two intervention projects from KSACS and KHPT. Hence it is expected that they will obtain other projects to support themselves.

These were the major achievements of CVCTC+ project in relation to sustainability. However, DIC and other related activities of CVCTC+ stands closed as on 31st Dec 2009.

WINS
The positive women’s group is strengthened and continues their work in the community which includes counselling and referral services. All project staffs continue their work. Due to non-availability of operational funds for rent and payment of the doctor’s salary, the CVCTC+ stands closed. As and when the operational funds are mobilized the community wants to set up the centre in some other slum.

FIRM
The Board of FIRM had both informal and formal rounds of discussion with the Trivandrum Corporation authorities, government sector, KSACS, IMA and a few civil society forums like FRAT (Federation of the Resident’s Association in Trivandrum) regarding the continuation of CVCTC+ in its current form. The discussions did not yield desired results. However, five community groups are sufficiently empowered to take on issues of stigma and discrimination and help the members of marginalized group access government health care services.

INP+
Present activities under the CVCTC+ project which extend support for Villupuram and Ariyalur District Networks in Tamil Nadu will continue through the ACT program of INP+. All the activities will be integrated through this support. The Trivandrum district level networks have initiated income generation programs such as preparing soap, detergent office covers for the PLHIV community, while the community is involved in the marketing of these products. This small amount is deposited in the corpus fund of the network. As far as the activities are concerned the network will integrate the activities with the DIC program under KSACS and the information centre which is supported in this program will continue through CPK+ (Kerala network) support.
SIAAP
The activities in the current form have been discontinued. The female sex workers are linked to already existing CBOs in the district who are providing counselling, referral and crisis intervention services. The community counsellor will continue to provide services as part of CBO. The place to conduct support group meetings have been coordinated and fixed with another NGO working in the area and care homes. The funds for nutrition are being gathered locally.

Samraksha
All the activities of the CVCTC+ have been handed over to the local PHC, whose staffs have been involved in providing care for CVCTC+ clients in need of additional services from the ICTC. A smooth transition has taken place. More importantly, the community groups (PLHIV and PIE) are supporting the PHC in continuing to ensure an environment that is friendly and respectful. The two peer counsellors will continue at the ART centre if resources can be raised; the ART centre wants them, but is unable to pay their salaries. Samraksha sees its future role as strengthening the CBOs and networks (WSW, SM and PLHIV, and Community Volunteer networks) to take on community monitoring of rights and entitlements and service access in the district, and programme and policy advocacy.

Initially it has been discussed if, for sustainability purposes the CVCTC+ centres would be taken over by the government after the end of the project. However, as there was huge scale up of Government run CVCTC+, it was not possible for the partners to hold any discussions with the government officials. However, one centre run by Humsafar Trust was taken over by Maharashtra SACS.

2.7. Has the Action promoted gender equality, disabilities....?
This project has definitely worked towards promoting gender equality. The coalition members often challenge the traditional definition of gender. The members of the coalition irrespective of the target group with which they worked had gender sensitivity. The project has not only treated man and woman as equals but has provided safe spaces to the third gender. This was particularly seen in the drop-in centre of Sangama, Humsafar Trust and SWAM. Here it was seen, that members often walk in with one identity, (for example, man) but remain throughout the day as woman. Once they are out of this “safe space” they revert to their accepted social identity. The partners also joined hands in national consultations regarding Sec 377.

All partner organizations were concerned about the rights and entitlements of women as they felt that in the whole gamut of HIV epidemic there is no single programme for women. For instance, TIs among female sex workers is to prevent infection to her client; similarly the PPTCT programme is designed to protect the unborn child from infection. Hence, whenever a woman is a victim of gender power the partner organizations have taken up the issues brought them to the public realm and addressed them. The partner organization also worked towards strengthening women’s networks. They also took initiatives in getting the cases resolved with regard to positive women in the areas of societal discrimination and property rights by organizing public hearings and inviting people who could influence decision making or expedite the process.

2.8. How and by whom have the activities been monitored/evaluated?
The activities have been monitored by different people at various levels.

1. Communities
At the Community voluntary counselling and testing centre, the activities were monitored by the communities involved right from the process of establishment of the centre, identifying the staff and reaching the community. In all centres, community members monitored the various activities. The community was more involved to see if their specific needs were being met. They were not particularly interested as to how many were reached or how many got tested, but took keen interest in knowing whether the centre staff is doing their job well, coming to the centre on time, adopting a friendly approach with the community, respecting the community and the like. They also gave suggestions regarding various sensitization programmes that would be effective and suggested appropriate IEC material for the community. Interestingly, it was observed that after a village education meeting where the services offered at the centre was announced, the representatives would first visit the centre, undertake fact-finding and verify the availability of services as claimed by the staff. Only when they were satisfied, they would return to their village and encourage people to access services.

Summary of feedback received and follow up action/results
From time to time the community gave feedback on project performance and there were times when the project staff initiated community consultations to understand the need and changes to be initiated.

a) The community after assessing the low uptake of CVCTC+ services gave feedback and suggestions to change the timings of the centre, to have a beauty parlor in the centre, change the timings of outreach work, to install pay telephone at DIC, install condom vending machine for luxury condoms, all of which were incorporated immediately. All this had a positive bearing on the uptake of CVCTC+ services.

b) Positive people gave feedback/suggestions regarding home based care and other care training. Accordingly volunteers were selected who were given series of care training and taking care of people at their home/facility and as well as in the community. They are the good motivators to other family members to care for PLHIV at home.

c) Suggestions for camps (STI and RTI), training and sensitization to specific population like police or CRPF, specific IEC materials regarding adherence and nutrition were immediately planned and implemented. In one centre, PLHIV suggested that having a pill box to store medicines would be of immense help.

d) When the community members expressed the need for small savings amongst them, a consultant was called and it was implemented after the necessary training. The money saved was used in time of crisis by women for paying fines in police custody or for a child’s school fees or to redeem jewels from money lenders.

e) When PSW community were harassed by police and rowdies, community suggested that a committee be formed consisting of members from community along with non-community project staff. They could visit the police station regularly and update them regarding the work in the centre so that they were able to command respect. This resulted in police keeping the centre informed when a woman was arrested or needed help. One destitute woman who was mentally challenged and pregnant was lying in the busy bus stand with clothes covering her partially. The police informed community staff at the centre and they attended to her, took care of her till her the delivery and even performed baby showers and kept her happy.

f) The community groups wished to register themselves and understand the different processes through exposure visits to similar organizations. After the exposure visit and gaining understanding they have negotiated to register two groups.

g) In one centre at Theni, there was an ongoing conflict amongst women in sex work regarding poaching of one’s client. A woman would have negotiated for a certain sum with the client in exchange for sexual services many times. Knowing this fact, other women in the centre would strike a deal with the same client for a lesser amount. When one woman takes another woman’s partner as her client, conflicting situations arose. To effectively resolve such issues, community members formed a grievance cell committee. The committee would receive complaints, hear both parties and after discussion with the members of the group try to resolve the issues.

2. Community Based Organizations / Community Advisory Board

Community Based Organizations in the coalition namely, HST, Sangama, SWAM and INP+ have their own Community Advisory Board which monitors the project regularly. Also in the case of SIAAP, the project is monitored by WSW CBO functioning in the District. The project Officer submits the monthly report to the CBO on their monthly meeting day.

3. Peer monitoring

PMC decided in 2007 that two members would jointly visit the partner organization’s project site, interact with the community, assess the project’s performance and give feedback to coalition members.

Feedback:

- Linkage chart about both client inflow and outflow to be displayed.
- Getting feedback from clients who have been referred outside about their satisfaction about the services.
- Constantly identify barriers at ICTC and see that they do not exist in CVCTC+. Also document the steps taken.
- Displaying board at prominent places about the centre.
- Document the outcome of each activity, for example after Panchayat resolutions are passed, keep record of number of people accessing centre from those villages as well as track whether any specific cases of stigma and discrimination are emerging from those places.
- Facilitating effective linkages between old sangams and new sangams.
- Relevant charts depicting outreach work both in different activities and relative outcomes.
- Details about testing can be displayed in the laboratory.
- Disposal of waste should be dealt with carefully by the local administration.
- The log frame and Gantt chart to be translated in the local language in order to ensure proper understanding of the concept of CVCTC+.
• Exposure visit to other CVCTC+ to help widening of the functioning.
• UP and PEP posters to be translated in native language.
• Community involvement to be increased constantly.

All the suggestions were implemented with immediate effect, and, it was observed over a period of time that ownership was increasing.

4. Project Staff
The project is closely monitored by the project officer on an ongoing basis. He conducts the weekly/monthly review meetings and helps the team plan their activities in tune with overall objectives/activities. He also undertakes a daily debriefing with the staff, weekly meeting and conducts monthly review meetings. He is also responsible for monthly reporting to central or coordinating office, for all documentation. The project officer’s work is monitored or supervised by the coordinator in the central office.

5. Central office
The central office monitors the performance of the project, the performance of staff the direction of the project in line with commitments made to donors/beneficiaries. From time to time, the project is also reviewed by peer coordinators who bring new energy or inputs.

6. Lead agency level (SIAAP)
The lead agency (SIAAP) receives both the technical and financial data on a monthly basis, collates this data, verifies data with the final results and presents the data during PMC meeting initiating discussion and planning necessary actions. Lead agency used tools such as activity chart and log frame to monitor the project. In the interim, the issue of linking up positive clients identified from the CVCTC+ to DLN affected the project outcomes. The PMC opted for external mediation and the following mechanisms were suggested:

- A meeting to discuss the project and national coalition between the project manager and District level Network of INP+
- The project manager of CVCTC+ refers positive people to DLN
- Monthly meetings between the project manager of CVCTC+ and DLN to discuss progress on the project.
- Project manager of local partner and DLN to send report to project manager of INP+ on monthly basis
- Any conflict situation arising due to any issue be informed to the project manager of INP+ with CC to DLN or vice versa.
- INP+ manager to intervene and make efforts to resolve issues between the local partner and DLN
- INP+ manager to escalate and inform senior management of INP+ in case of failure to find solution to the crisis situation
- Project Manager to escalate and inform senior management of partner in case of failure to find solution to the crisis situation
- Senior management of INP+ and local partner to intervene to help find a solution to the crisis situation
- Failure at all levels to resolve crisis should invite mediation from the PMC
- Failure to resolve crisis at PMC should invite external mediation

- Internal mid-term evaluation March 2008
The internal self-evaluation process was initiated in March 2008. The Project Management Committee noted that as the project had already completed 2 years, there was a need for a mid-term evaluation. Members felt that the evaluation should be participatory, and encompass standardized procedures, review impact, changed results and clearly bring out the intangibles. Discussions were also held on whether communities should be involved in the evaluation process. An overview of the assessment of the project progress on the ‘objectively verifiable indicators of achievement for the specific project objective’ and the related ‘expected results’ were done.

Findings:
1. Improved quality of life through seven functional CVCTC+.
   a. Seven CVCTC+ were established and most tasks to be undertaken (in relation to CVCTC+) with the funds provided were undertaken by various partners. A few centres also provided additional services like STI testing, hepatitis B vaccination.
   c. The number of clients who received post-test counselling against those who opted to be tested was on an average around 76% in 2007 and a little higher at 78% in 2008.
d. Several cases of stigma and discrimination were dealt with by different centres, and there were also successful attempts at exploring alternate livelihoods.

2. Effective alliance of target communities through sixteen representative functional groups.
   a. Each of the 8 partner organizations of Sarvojana has a history of working with one or more groups vulnerable to HIV and AIDS. The project therefore had hoped to promote 16 representative and functional groups around each CVCTC+, which could possibly -
   b. Take ownership of work around issues of stigma and discrimination.
   c. Provide post-project continuity in one form or another
   d. Engage in public education on issues of sexual preferences
   e. Be key partners in the advocacy agenda.
   f. The project appears not to be monitoring the promotion and functioning of these groups as numbers of members, work done by the groups promoted were not readily available, though at some places it was seen that they were doing remarkable work.

3. Improved services through government agencies and Civil Society Organizations
The project aimed at engaging government agencies and other civil society organizations around the project area so that they started/added initiatives based on learning from CVCTC+ model and network processes. This was expected to result in improved quality of services available at government, private and community facilities for a continuum of care for HIV and AIDS prevention, treatment delivery, care and support for target communities.

Tasks to be undertaken in this regard was completed as per activity chart, except that it was not clear as to what kind of training materials were produced, who were trained. From the self-assessment report, it was not clear whether each coalition partner had, in place, a set of identified local institutions that it wanted to influence and a strategy in place to influence these, using CVCTC+ and the local community organizations as change agents.

4. Effective umbrella organization working to reduce stigma and discrimination and increase access to services.
The project had hoped to have a functional consortium of civil society organizations working to reduce stigma and discrimination and increase equitable access to HIV and AIDS prevention, treatment delivery, care and support, among PSW, GBT, PLHIV and PIE.

In terms of tasks to be undertaken, most project management functions were fulfilled. Work related to advocacy with government (study of best practices, workshop with government to share best practices and influence policy etc) was meant to be taken up at a later stage in the project period.

However, some spadework was probably required at an earlier stage, if, before the closure of the project, policy was to be influenced.

PMC appears to have conducted itself with dignity despite facing some very challenging issues of coalition. Some of the PMC representatives are persons of extraordinary skill, commitment, and repute, and have years of experience in governance and management issues. While some of them extraordinary skills and experience in advocacy, and were applying these in their own organizational work, there did not appear to be any concerted joint advocacy action by the coalition, as anticipated during project formulation.

Any coalition of the complexity that Sarvojana has, will initially use its energy to establish itself for smooth collaboration around project management, but this coalition has the sophistication necessary to also develop into a strong advocacy group, overcoming individual differences and arriving first at what one partner has termed a common minimum programme and then working concertedly towards influencing legislation and policy.

7. Hivos monitoring

- External evaluation March 2009 – August 2009 (initiated by Hivos)
Though this evaluation was to happen during the mid-term of the project, it began in March 2009 and ended in August 2009, almost during the end of the project which gave little or no scope to make any corrections. An overview of the evaluation of the project progressed on the four ‘objectively verifiable indicators of achievement for the specific project objective’ and the related ‘expected results’ was done.

Key findings
Overall
Throughout the life of the initiative, there has been a tension between the project as a vehicle for service delivery and action, and the coalition as a facilitator of voice. The project has been successfully implemented. The coalition has made significant progress towards achieving the outcomes that it aspired to at its inception.

Expected Result 1: Improved quality of life of PSW, GBT, PLHIV and PIE
This outcome has been achieved. The coalition members who have established CVCTC+ have built and operated good practice programmes where counselling and testing is integral to providing access and avenues to care, support and treatment needed by community members.

Establishment of CVCTC+ has fostered community feeling, community formation, community self-organizing, and community organizational development.

The CVCTC+ creates safe spaces and promotes solidarity and a sense of purpose. These generate self esteem and self worth whereby positive living takes centre stage.

**Expected Result 2**: Improved quality of services for care, treatment and support for marginalised and vulnerable groups.

- The project has created self-help community groups with a sense of purpose and allowed them to grow organically rather than programmatically.
- Coalition partners have to clearly identify what roles they want these groups to play in dealing with cases of injustice, violation of rights and on creating a social justice-based response to the HIV epidemic.

**Expected Result 3**: An effective institutional and legislative environment for reducing stigma and discrimination against marginalised and vulnerable groups.

- It was not clear that the importance of expected result 3 in improving the quality of life and well being of the communities of interest has been reflected in project implementation.
- Change in the immediate social environment is palpable and persons in the immediate environment have demonstrated a great deal of support.
- The project moved beyond sensitizing health care providers to working with them towards the nature of service delivery, notwithstanding the day-to-day challenges.
- The project has demonstrated community capacity in health promotion and the achievement of social justice.

**Expected Result 4**: Effective functioning of an umbrella organisation

The project management committee fulfils this function and fulfils it effectively. There are some issues of continuing concern in the quest for good governance:

- The need for conflict resolution mechanism outside of the regular PMC.
- The need for continuity of representation on the PMC and representation at the senior level.
- Inadequacy of the transfer of vision of the coalition and of project approaches and components to new PMC members.
- The tools and indicators used to capture outcomes, in particular log frame and MIS, have not been adequate to capture the way the coalition works and its achievements.
- Log frame approach needs to be combined with other approaches more able to capture and measure subtlety in complexity and to contribute to a deeper understanding of how to bring about lasting social change in complex and ethically problematical situations.

**Detailed recommendations** were given on page 68 of evaluation report. Recommendations which would be useful for future work of coalition are as follows:

- The work of coalition organizations be better theorized, documented and disseminated so that their real achievements can contribute to the development of communities of effective HIV practice in India and elsewhere.
- The differing governance needs of the coalition and the project be clarified and an appropriate governance structure be developed for the coalition.
- Sarvajana create a programme position to support its programme of action and advocacy as a coalition of organizations speaking with unified voice concerning the practices, ethics and effectiveness of HIV work in India.
- Ways to be found to ensure that Sarvajana’s vision and purpose is transferred to in-coming participants.
- Coalition reflect on whether it would be beneficial to gain new members, either individual or organizational and if so how they will balance the value of familiarity in processes of joint project management with the authority that could be gained from a larger group speaking with one voice.

7. **EC/Monitors appointed by EC**

From the initiation of the project, an external monitor appointed by EU has provided feedback. There has been one result oriented monitoring and three visits from EU, New Delhi.

**Key recommendations from the Result Oriented Monitoring report in Sept 2006**:

- Clarification regarding linking the project with reducing poverty
- Non availability of Kits and OI medicines
- Need for a Collective Advocacy Strategy. To incorporate and build a Financial Sustainability Strategy right from the beginning
• Empowering the community to handle the financial sustainability
• Numbers mentioned in the proposal are too ambitious and need to be re worked
• Need to develop good MIS
• To monitor expenditure to keep track of 70% expenditure criteria
• Consistency between various CVCTC+ keeping the diversity in mind

**Results of feedback**
The log frame was reworked with realistic figures and indicators kept simple for easy tracking to accommodate the evaluators’ feedback. MIS was also developed in the second year to record and analyze the CVCTC+ data. In instances where the centre did not receive supply of test kits from the government, the staff, after counselling clients, accompanied them to government health care facilities for testing. The expenditure was carefully tracked and all the activities were done as per activity chart.

**- Key recommendations EU Mission in Oct 2006:**
- To use the budget within the frame of the approved budget and the General Conditions of the contract.
- Simplify the existing log frame and work out a 1-page summary log frame that (i) focuses on the three upper levels of the log frame: overall objective, specific objective, expected results (ii) captures the gender diversities of the project, (iii) will enable to track if, and up to which degree, improvements and changes are taking place, at different levels;
- Develop an MIS system in place for collecting, compiling and analyzing minimum information that will be required for reporting against indicators formulated in the log frame. The system MUST be results and change oriented, not activity-focused;
- Review the actual status of community empowerment / how much project initiatives and activities being undertaken are community-led, -managed and -owned. In particular, each implementing partner should assess, as of today, and over time, till project ends, (i) which tasks are performed by whom (communities, NGO, other service providers), (ii) which costs and resources are covered by whom (communities, NGO, other service providers), and (iii) how task and cost sharing evolve over time / how much communities become empowered over time to make decisions that benefit them on health and STI/HIV-related issues;

**Results of feedback**
The budget was carefully planned and spent. The project developed simple log frame and indicators based on which a revised MIS was developed. To capture more qualitative information each partner carefully documented the changes and impact.

**- Summary of feedback received EU Mission in August 2007:**
Review project design with respect to:
1. Operational strategies to address income poverty;
2. The concept of the alliance of partners;
3. The partners’ capacity-building strategy;
4. The sustainability of the CVCTC+.

**Follow up:**
The above points were taken up at PMC and other appropriate forums. Activities were planned accordingly and detailed discussions were held in aspects related to poverty and sustainability. PLHIV groups under DLNW were given specific training on income generation programmes. Reduced loss of working days due to improved health-seeking behaviour was looked at as a chief contributor towards addressing income poverty.

**- Observations from Result Oriented Monitoring in May 2009**
1. **Sustainability / Phase out strategy**

PMC response:
- At the beginning of the project, the idea was to hand over the CVCTC+ to communities for them to manage. However, as the project progressed communities reviewed the situation and there was better clarity on some areas.
- Sustainability was seen as sustainability of the change that the community groups experienced in the way the larger community viewed them and their participation in the social, economic and political life of the community. This included access to services. The goal being this change, sustainability of this change was the core rather than sustainability of the CVCTC+.
- In some contexts, the CVCTC+ continued to be necessary to sustain the change and the partners would look for new sources of funding to run it. In the context of other partners, sustainability had already been achieved through the ownership of the process of change by the community through the CVCTC+. Here, the community would sustain the activities that brought the change, through running of the CVCTC+. It would need to identify a source of funding. In yet other contexts, the
change demonstrated through the CVCTC+ could be replicated without running a full CVCTC+. Here, certain components of the CVCTC+ like counselling, community support groups, service facilitation support, local advocacy would be components continued to sustain the change. These would be handled by community groups or organizations. These would be located in the Community Centre in some contexts and within the government run ICTCs in other contexts. The latter is seen as a way to replicate the desired qualities of the CVCTC+ such as respect for the community, space for mutual sharing and support, information and inspiration for positive living, all of which communities did not feel they currently experienced in the existing government run VCTC.

- The broad strokes of the phase out have been drawn by the different partners. The details are being worked out now.

2. Clarification regarding Sarvojana advocacy role
If we see advocacy as the pursuit of influencing outcomes that directly affect people's lives, the project has been continuously speaking out on issues of concern to exert influence for this change. This may have been largely at the local level, except coming together on some state level or national level issues as they emerged in the area of mandatory testing, and violence against transgender communities. A lot of the time, the problem has been not in the policy, but the interpretation or implementation of the policy and hence local level advocacy has been critical.

3. EC and project visibility
The monitor's observation is that visibility is uneven among partners and use of local language should have been used.

PMC response: PMC agreed to monitor's recommendations. They proposed to get the visibility material translated and share the same with all stakeholders.

2.9. What has your organisation/partner learned from the Action and how has this learning been utilised and disseminated?

There has been lot of learning for all the partners/ community/ staff working with different stakeholders during the currency of the project. The learning have been classified broadly under running CVCTC+, linkages/networking, through village programmes and working as coalition. There was also specific learning by working with different communities like PLHIV community, PIE, PSW/Sexual minorities.

CVCTC+
- Nothing works like connecting with people.
- Testing is not a one off service, but the beginning of a relationship with a service, which helps the person accept and live with the diagnosis of HIV.
- A community led CVCTC+ is able to effectively create a positive environment, where people are willing to test without fear. Sharing by the centre staff who are affected by HIV, results in the creation of shared experiences, which builds trust among the clients.
- Building and strengthening Social Forum helped to address many issues of the community as the members from social forums come from different segments of the society. This brings solidarity among various groups.
- If good quality services are given then even doctors from DOTS centre and other local practitioner send clients to the CVCTC+.
- By good counseling aiming to reduce fear around HIV, lead to increased post test collection rate.
- CVCTC+ was not only for testing, but a hub or a liaison between people with needs and the Government welfare Departments.
- Capacity of the community can be enhanced better by twinning them with the appropriate staff rather than just give training.

PLHIV Community
- Focusing on a wellness model, on how to stay well, motivates PLHIV to adapt positive living. This can be through nutrition training, individual planning on nutrition based on what is available and within their reach, complementary healing techniques like yoga and pranic healing, resilience training, which helps the affected people start looking at themselves from a position of strength, of their capacities and what they can do to positively influence their own lives and that of others helps the affected people with coping with stress but also see themselves as positive change agents.
- It is important to influence the immediate environment of the positive people to bring about change in the lives of positive people.
- Repeat counselling sessions helps ART adherence.
• Nutrition demonstration is meaningless as the poor cannot afford the time or the money or the energy to consume the menus that is demonstrated.
• Motivating children to attend school when parents are ill is futile.
• Training care givers along with positive people helps in the successful running of small petty shops, which was their choice of micro enterprise.
• Alcoholic males are hard to deal with, they neither listen nor allow their wife to talk to any health staff.
• It was learnt that support groups meetings poured new energy not only by providing nutrition but by giving valuable information on ART, side effects, effective management of OIs and above all a forum for members to speak free from heart and an opportunity to support people, with the little they could.

PIE Community
• Perspective building processes promote self or community referrals for testing. This feeds into a process of normalizing HIV, of creating a benefit perception about testing, so that more and more people access testing.

Linkages / Networking
• Familiarity with the centre brings desired results working with the government departments, and health care service providers. When they appreciate the systems they adopt it in their own.
• Violence from the police has direct bearing to the violence caused by rowdies, which reduced to a considerable extent when there was reduction of violence by police, in the project areas.
• Networking with different people Government, Networks, other NGOs, CBOs and key people like Police, Lawyers, Panchayat presidents, ensures sustainability of service delivery and enabling environment for people from different communities both during and after the project period.

PSW and Sexual Minorities
• The different communities affected by HIV, like women in sex work, sexual minorities, people living with HIV, and the general communities do not always share similar issues or relate to each other. But bringing them together and allowing a space for sharing of ideas, experiences and stories, helps them understand and appreciate each other. This leads to not only a greater openness in accepting the members of the other communities, but also understanding of their lives, and an appreciation of their strengths. It builds relationships between these groups, so that they start supporting each other in coping with their problems, and working together for a unified HIV response.
• Increased information and knowledge levels of the community volunteers help community tremendously.
• It is possible to mobilize positive people group meetings by strongly creating a space and forum to share, ventilate and get emotional support from their peers. It was apparent from the increase in membership and from the attendance.
• Through constant and consistent motivation it was possible to bring about a desire to test for HIV among people from the community
• Violence faced by kothis can be significantly reduced by working with panthis.
• Aravnis and kothis could be integrated for the issues of marginalized group.
• Capacity building of the communities was essential element towards creating ownership. Especially people from the communities feel empowered when trained on particular skills and come forward to take up responsibilities.

Village Programs:
• In villages, privacy is a problem during counselling (widows, or adolescent girls) counsellor is unable to tell the family members to leave the place. Adolescent boys are busy as earners they are unavailable.
• Conducting meeting at velugu/public space attracts onlookers and meeting gets disturbed
• Social discrimination against girls is possible to overcome by LSE sessions.
• People from the general population are tired of HIV and there is poor scope for motivating people with low risk perception to test.
• There were resolutions passed at many Panchayats during the project period to sensitize people with regard to Stigma and Discrimination towards PLHIV. Although the Panchayat leaders included in their agenda and gave time during the gram sabha meetings, it was learnt that it was a process to be initiated among the different groups of people which should slowly percolate from the ground to the leaders in order to have an impact.
Lessons learned about working together as a coalition from the external evaluation findings

- Coalitions give rise to tensions and conflicts and need the ability to talk things through.
- There is a need to nurture coalition like any other organization though the individual organizations are well developed.
- There is a need for good governance mechanisms and procedures.
- The power of respectful partnerships between donors and recipient organization.

3. Partners and other Co-operation

3.1 How do you assess the relationship between the formal partners of this Action (i.e., those partners which have signed a partnership statement)? Please specify for each partner organization.

The relationship between formal partners of action namely Hivos and SIAAP has been extremely good over the years and it has further strengthened during this project. Hivos was involved right from the stage of conceptualization of the project. They also suggested a consultant to take the coalition through the concept of “problem tree” and “solution tree” which greatly helped in drawing up the Log frame for the proposal. During the project period they took interest in the functioning of the coalition as this was the first time NGOs and CBOs working with different target groups came together for a bigger common cause. Hivos periodically attended the PMC meetings and gave feedback. When the coalition was sailing through rough tides due to conflicting situation arising among partners it supported the coalition to resolve the issue amicably.

From time to time it also invited coalition members to different forums and workshop which helped them to strengthen their capacities and understand the epidemic globally.

3.2 Is the partnership to continue? If so how? If not, why?

SIAAP is working in partnership with Hivos in Rural Youth Project titled “Improving HIV Prevention and Care among Youth (15-29 years), FSW and MSM in Rural Tamil Nadu” (with EU funding).

3.3 How would you assess the relationship between your organization and State authorities in action countries?

The relationship between different authorities in the state like hospitals, police stations, authorities of local governance structure right from panchayat, collector have influenced the efficacy of the project in direct as well as indirect ways. The relationship between different partner organizations with the state authorities particularly with district health authorities is reasonably good. It improved in the project period of four years in the local area where CVCTC+ is located. By and large the relationship was built on working together rather than demanding the services at the hospital as the chief aim of the CVCTC+ was to make community access services. The organizations understood the real situation like shortage of staff, bureaucracy that existed in different structure along with their own limitations and planned their activities strategically to bring the desired change. The community started helping actively both staff and clients in the ART centres to meet with heavy rush. The rapport thus built not only helped in referring clients but also provided an opportunity to support the hospital staff both physically and emotionally, resulting in special care to clients referred from the CVCTC+. Through constant monitoring and exit interviews, it was found that there was improvement in the quality of care provided which resulted in improvement in the Health seeking behaviour of people enabling them to enjoy quality health services in their locality.

All the centres collaborated well with their state authorities. The key most important area in the project was maintaining rapport with State health authorities and State AIDS Control Societies. Advocacy with the Municipal Corporation, district medical officer, chief DOTs officer, Taluka Medical officer helped in organizing programs with college students, workers, doctors and paramedical staff.

All the partners had fairly good relationship with their respective State AIDS Control Societies. The chief contributing factor was that the organizations in the coalition were genuine, transparent in their operations, always had community perspective in their work and most of them were EC committee members, were often consulted on development of IEC, were involved in several training programmes of SACS as master trainers.

In the initial years of project, when the funds were not available for testing kits, most of the partners could convince the respective SACS to supply them. At times when the deficiency in services was pointed out SACS did not respond very kindly and Sangama had to resort to protest due to non availability of ART medicine in Bangalore. When SIAAP collected data from women in sex work regarding mass testing organized by TAI funded by Avahan the TANSACS responded immediately by
stopping the mass testing. By second year most of data emerging out of the CVCTC+ were fed into State data. From the second year onwards, the CVCTC+ data flowed into the State MIS.

In addition Sangama CVCTC+ was chosen as a HRG centre to conduct sentinel surveillance. Humsafar Trust collaborated with NACO and their observations were included in the national guidelines. SWAM SIAAP and INP+ closely worked with TNSACS. Samraksha also had good rapport with KSACS and their contribution in the Sirwar region was given due recognition. 5 out 7 centres were accredited by SACS. FIRM did commendable work by filing legal petition in the area of stigma & discrimination. In one such case they became unpopular with KSACS. FIRM, even after making possible efforts, could not establish rapport with KSACS as they supported a community member to sue the PD of KSACS for his/her speech accusing Sex workers for being cause of infection. FIRM turned down the request made by several officials from KSACS to withdraw the case. Because of this incident, FIRM CVCTC+ was neither accredited nor provided test kits.

Village/ Urban/Slum authorities:
All organizations had regular meetings to sensitize people and the elected representatives on the various issues faced by PLHIV, focusing especially on Stigma and Discrimination. Most of the Village Panchayat office bearers were sensitive and they responded well in support of the program. They gave permission to conduct meetings in the villages and pass resolutions against discrimination towards PLHIV during the Village Gram Sabha Meetings, etc. In urban and semi urban settings the municipal leaders or star fan club and SHG members facilitated the process.

District Administration:
All CVCTC+s coordinated well with the district administration. In the third year of the project, the DAPCU was set up. The centre staffs were invited to attend meetings and share their data, learning and challenges. Some centers functioned as information centres by helping clients’ access welfare schemes from the Government. The staff from CVCTC+ made frequent visits to the various departments of the District Administrative Office. In the due course they have both established good rapport and learnt about the various requirements for applying for schemes. This not only minimized the number of times a client had to meet the official for applying but also reduced the work load of the Official as the applications were filled properly and all annex attached.

Police:
Since most organizations worked among marginalized groups who were abused /harassed by police, there was a strong need to establish linkage with the police personnel in order to create an enabling atmosphere for community to lead their life peacefully. Partner organization specially targeting marginalized groups conducted ongoing police sensitization programmes, visited regularly and built rapport with the local police authorities.

3.4 Where applicable describe your relationship with any other organizations involved in implementing the Action:
- Associates if any - NA
- Sub contractors - NA
- Final beneficiaries - The relationship with all final beneficiaries is very encouraging. The target communities look upon Siaap and other partners for support whenever any violation of right is felt by the community.
- Other third parties involved - NA

3.5 Where applicable outline any links you have developed with other actions
During the course of this action all partner organizations in the coalition developed close links with District health and administrative authorities, NGOs/ CBOs in the area. When breach of confidentiality was seen during the mass testing done under TAI project funded by Avahan several agencies like THAA, Sahodaran, Samuthiram, Freedom Foundation and SMIS joined hands.

3.6 If your organization has received previous EC grants in view of strengthening the same target group, in how far this action has been able to build upon/ complement the previous one?
Not applicable

3.7 How do you evaluate cooperation with the services of the contracting authority?
The cooperation with the contracting authorities namely HIVOS was very valuable. As this was the first project we were implementing from EC, HIVOS was particularly supportive in making us understand both the technical and financial requirements and guided from time to time. Also, whenever there was
any seminar or workshop conducted by EC, HIVOS encouraged the partners to participate. HIVOS also encouraged the community and coalition to submit abstract for the International AIDS conference and helped the participants by making logistic arrangements, which helped the participants greatly at a new place. Also at the time of submission of interim reports the queries raised by EC were followed up swiftly by HIVOS which made the financial resource flow easy.

4. Visibility

How is the visibility of the EU contribution being ensured in the Action?

The contribution from EU/HIVOS is recognized by all partners and wherever there is any event big or small the EU contribution is made visible by putting big banners during the event. The invitation letters for forums, trainings, workshops also acknowledge EC contribution.

EC contribution can be constantly seen in the CVCTC+ boards, in all IEC materials, all publications, DVD/CD and other materials. EU logo can be seen in all condom boxes, condom outlets, advertisements in buses where the CVCTC+ services were advertised.

From time to time we have been sending all visibility materials along with interim reports. We are sending the hard copies of all the materials published in the last year along with this report as annexure. The entire list of publications which has EU logo is given under Sec. 2.4 (pages 40 & 41). The concept of coalition and CVCTC+ were showcased in Mexico Conference in the form of posters and also in HIVOS global village acknowledging the contributions of EC.

The European Commission may wish to publicise the results of Actions. Do you have any objection to this report being published on EuropeAid Co-operation Office website? If so, please state your objections here.

Name of the contact person for the Action: Ria Hulsman

Signature:

Location: The Hague

Date report due: 30/6/2010

Date report sent: