INDIA'S INTERVENTION IN HIV PREVENTION

A Collection of Best Practices

National AIDS Control Organisation

USAID FROM THE AMERICAN PEOPLE

PEPFAR

SHARE PROJECT - VHS

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BEST PRACTICES FOUNDATION

Foreword

सत्यमेव जयते

एन॰ एस॰ कंग, भा.प्र.से
अपर सचिव
NAVREET SINGH KANG, IAS
Aditional Secretary

NACO

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation

FOREWORD

India's AIDS Control Programme is widely recognized as a success story. Led by the National AIDS Control Organization (NACO), it has resulted in an overall reduction of 57% in the annual new HIV infections among adult population from 2.74 lakh in 2000 to 1.16 lakh in 2011, reflecting the positive impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme (NACP).

The lessons learnt from India's effort towards HIV prevention with a focus on high-risk groups [encompassing female sex workers (FSW), men who have sex with men (MSM) and injecting drug users (IDU)], need to be distilled, and imbibed, and widely disseminated among other Asian and African countries facing similar challenges. NACO has initiated a South-To-South Knowledge Exchange (S2SKE) on HIV / AIDS with the aim to contribute to the improvement of the global AIDS response, by showcasing India's success and transferring the learning to partner countries. The Secretariat for the S2SKE initiative has been facilitating the South-To-South related knowledge with exchange activities to select countries in Africa and Asia, and has encouraged bi-directional knowledge transfer over the years.

I am pleased to learn about the release of twenty Best Practices Document on prevention services of NACO. This booklet is a step towards sharing India's best practices on HIV prevention with partnering countries and the domestic audience. I am confident that this documentation will be useful for facilitating cross learning and dissemination as part of the knowledge transfer.

I take this opportunity to acknowledge the support extended by Mr. K.B.Agarwal (IAS), former Joint Secretary in NACO; Dr. Neeraj Dhingra, Deputy Director General; Mr. Jimreeves K, Donor Coordinator & Team Leader, Secretariat for South-To-South Knowledge Exchange (S2SKE) initiative; and Mr. Utpal Das, Specialist – Knowledge Transfer to bring out these Best Practices Document on Prevention. I also gratefully acknowledge the considerable expertise and insights provided by all the other colleagues who directly or indirectly contributed significantly to this process.

I also thank and appreciate the effort of Dr. Joseph D.Williams, Project Director and Dr. T.Ilanchezhian, Technical Advisor & Team Leader and all staff of SHARE-VHS for bringing out this publication.

(N.S.Kang)
Additional Secretary, NACO

6th Floor, Chandralok Building, 36 Janpath, New Delhi -110001, Tele : 011-23325331/ 23351700, Fax : 011-43509931
E-mail : nacoasdg@gmail.com

अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ
Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

Preface

The South-To-South HIV/AIDS Resource Exchange (SHARE) project is an initiative funded by United States Agency for International Development (USAID) through the United States President's Emergency Plan for AIDS Relief managed by CHARTERED, a public health arm of Voluntary Health Services (VHS), Chennai through a cooperative agreement. Its goal is to strengthen the national HIV/AIDS response in India and select African countries by facilitating technical cooperation through a bi-directional transfer of high impact policies, practices and innovations. Such collaborations encourage mutual sharing of experiences and the exchange of best practices and innovations between countries in Africa, Asia and the Indian sub-continent. The three focus areas are Country Ownership and Stewardship; Prevention, Care, Treatment and Support; as well as Programme Support Systems. Using a proven knowledge sharing and adoption methodology, Assessment, Share, Adopt and Follow-up (ASAF), the technical cooperation approaches include country profiling, exploratory visits, guided exposure visits, in-country technical support, knowledge repositories, virtual support, and follow-up visits, amongst others.

The SHARE project has developed Standard Operating Procedures, learning packages for Guided Exposure Visits, and training manuals for the Key Population Fellowship Programme. It has also established an online repository on HIV/AIDS along with the tools and guidelines for Situation Needs Assessment. In partnership with India's National AIDS Control Organisation (NACO), the SHARE project has developed 39 Knowledge Exchange Sites and capacitated 111 delegates representing 12 African countries through various approaches. It has cultivated best practices in private sector engagement in HIV/AIDS as well as in Country Ownership and Stewardship.

Along with NACO, SHARE identified 97 practices covering prevention, basic services, care, support and treatment that have been instrumental in reducing the number of new annual HIV infections by 57%. SHARE collaborated with the Best Practices Foundation (BPF) to complete the documentation of 20 of these best practices on prevention as part of phase I. We take this opportunity to commend NACO for their extensive technical input and constant guidance in this endeavour.

At the outset, I would like to thank Mr N S Kang (IAS), Additional Secretary and Mr K B Agarwal (IAS), Joint Secretary for their support. My sincere gratitude to all the Deputy Director General of NACO viz., Dr. A S Rathore, DDG (CST); Dr. R S Gupta, DDG (BSD, BTS & STI/RTI) and Dr. Naresh Goel, DDG (LS & IEC). We offer our special gratitude to Dr Neeraj Dhingra, Deputy Director General (TI, MnE&R, & KS), NACO for his valuable help and guidance in bringing out this best practice document. Without their co-operation and encouragement, we would not have come so far. We are extremely grateful to Mr Jimreeves K, Donor Coordinator and Team Leader, Secretariat for South-To-South Knowledge Exchange (S2SKE) initiative, NACO who took the lead role in planning, coordinating, and providing technical input. His committed initiative and continuous support in the finalisation of these best practices on prevention is highly laudable. We also sincerely express our gratitude to Mr Utpal Das, Specialist – Knowledge Transfer (Africa - S2SKE) for his technical support, coordination and painstaking follow-up between NACO and BPF. We gratefully acknowledge the considerable expertise and insights of Mr Deepak Dobhal, Team Leader (NTSU), Dr Rajesh Kumar Rana, Account Director (Media), Dr T L N Prasad, Technical Expert (STI), Mr Srikar Panyam, Technical Expert (NTSU), Dr Govind Bansal, DAPCU Coordinator (NTSU), Mr Shantanu Purohit, Technical Expert (Migrants), Mr Kannan Mariyappan, Technical Expert (NTSU), Mr Y Anthony Reddy, Technical Expert (NTSU), Mr Manishankar Kumar, Technical Expert (NTSU), Ms Sophia Khumukcham, Programme Officer (IDU), Mr Ugramohan Jha, Programme Officer (Statistics), Mr Abraham Lincoln, Technical Expert (IDU/Harm Reduction), Mr Animesh Purohit, Programme Officer (Truckers), Mr Sudarshan Negi,

Communication Manager - Technical Study Group (Condom), as well as all the other officers who directly or indirectly contributed significantly to this process.

We especially wish to acknowledge and thank the financial support extended by USAID/INDIA mission to VHS for supporting the global knowledge transfer initiatives of the SHARE project for the last three years. We also wish to show our appreciation for Mr P Arvind Kumar, Programme Management Specialist – PHN for his support and guidance.

Dr T Ilanchezhian, Technical Advisor & Team Leader, SHARE-VHS has been the key mover behind this innovative initiative, providing overall technical assistance, evolving guidelines, developing templates, reviewing and providing suggestions, coordinating with NACO for finalisation of the best practices and being responsible for bringing out this folder along with 20 best practices. The invaluable contribution of the SHARE team, especially Mr K Pramod, Technical Manager – Prevention and Ms T Sudha, Program Associate needs to be warmly acknowledged.

We thank Dr S Suresh, Honorary Secretary, Voluntary Health Services (VHS) for extending his dynamic leadership and management support in planning, managing and execution of the SHARE project activities.

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Once again, I thank NACO for the privilege of collaborating on the knowledge transfer initiatives between India and Africa and in the process, bringing out this series. I trust that these effective and established best practices on HIV prevention in India will prove useful for policy makers and practitioners around the world.

Dr Joseph D Williams
Project Director – SHARE Project
Chennai, India

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National AIDS Control Organisation
Mr N S Kang, (IAS), Additional Secretary
Mr K B Agarwal, (IAS), Joint Secretary
Dr Neeraj Dhingra, Deputy Director General (TI), NACO
Mr Jimreeves K, Donor Coordinator & Team Leader - Secretariat for South-To-South, NACO
Mr Utpal Das, Specialist - Knowledge Transfer
Mr Deepak Dobhal, Team Leader (NTSU)
Dr Rajesh Kumar Rana, Account Director (Media)
Dr T L N Prasad, Technical Expert (STI)
Mr Srikar Panyam, Technical Expert (NTSU)
Dr Govind Bansal, DAPCU Coordinator, (NTSU)
Mr Shantanu Purohit, Technical Expert (Migrants)
Mr Kannan Mariyappan, Technical Expert (NTSU)
Mr Y Anthony Reddy, Technical Expert (NTSU)
Mr Manishankar Kumar, Technical Expert (NTSU)
Ms Sophia Khumukcham, Programme Officer (IDU)
Mr Ugramohan Jha, Programme Officer (Statistics)
Mr Abraham Lincoln, Technical Expert (IDU/Harm Reduction)
Mr Animesh Purohit, Programme Officer (Truckers)
Mr Sudarshan Negi, Communication Manager, Technical Study Group (Condom)

USAID India Mission
Mr P Arvind Kumar, Programme Management Specialist - PHN

SHARE project - Voluntary Health Services
Dr Joseph D Williams, Director- Projects
Dr T Ilanchezhian, Technical Advisor & Team Leader - Prevention, Care, Support & Treatment
Mr K Pramod, Technical Manager – Prevention
Mr T Shankar, Finance Advisor
Ms T Sudha Program Associate

Best Practices Foundation
Dr Sangeetha Purushothaman, Executive Director
Ms Sudha Menon, Chief Designer
Ms Natasha Ravindran, Copy Editor
Ms Sara Joseph, Research Associate

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Abbreviations

A/C	Accounts
ANC	Ante Natal Clinic
APAC	AIDS Prevention and Control
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation
CIG	Common interest groups
CMIS	Computerised Management Information System
CoE	Centres of Excellence
CPFMS	Computerised Project Financial Management System
CSMP	Condom Social Marketing Programme
DAC	Department of AIDS Control
DACO	District AIDS Control Officer
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-In Centre
DOTS	Direct Observation Treatment Short-Course
DSRC	Designated STI/RTI Clinic
ELM	Employer Led Model
EPAN	Expert Physician Access Number
ESCM	Enhanced Syndromic Case Management
FSW	Female Sex Worker
HRG	High Risk Group
ICASA	International Conference on AIDS and STI in Africa
ICST	Immuno-Chromatographic Strip Test
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
IPC	Inter-Personal Communication
KO	Knowledge Olympic
KP	Key Population
KRC	Knowledge Resource Centre
KSSA	Karnataka Souharda Sahakari Act, 1997
LWS	Link Worker Scheme
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MCH	Maternal and Child Health
MHC	Master Health Check-up
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NABARD	National Bank for Agriculture and Rural Development
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NACP I	Phase I of NACP (1994-1999)
NACP II	Phase II of NACP (1999-2006)
NACP III	Phase III of NACP (2007-2012)
NACP IV	Phase IV of NACP (2012-2017)
NDLS	National Distance Learning Seminar
NERO	North-East Regional Office
NGO	Non Governmental Organisation
NHM	National Health Mission
NRHM	National Rural Health Mission
NTSU	National Technical Support Unit
ORW	Out Reach Worker
OST	Opioid Substitution Therapy

PE	Peer Educator
PLHIV	People Living with HIV
PO	Programme Officer
POC	Point of Care
PIP	Programme Implementation Plan
PPP	Public-Private-Partnership
PPTCT	Prevention of Parent To Child Transmission of HIV/AIDS
PWID	People Who Inject Drugs
RMC	Regular Medical Check-up
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
RU	Reporting Unit
SACS	State AIDS Control Society
SCM	Syndromic Case Management
SIMS	Strategic Information Management System
SLPs	State Lead Partners
SMOs	Social Marketing Organisations
SOP	Standard Operating Procedure
SP	Spasmoproxyvon
STAT	Same-day Testing and Treatment
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centres
TANSACS	Tamil Nadu State AIDS Control Society
TO	Technical Officer
TG	Transgender
TGWB	Tamil Nadu Transgender Welfare Board
TI	Targeted Intervention
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
UID	Unique Identification
VDRL	Venereal Diseases Research Laboratory

Introduction

India has the third highest number of people living with HIV (PLHIV) in the world estimated at 2.09 million in 2011. Women and children account for 39 percent of all PLHIV and 7 percent of all HIV respectively.[1] At the end of 2013, more than 700,000 people in India were on Antiretroviral Therapy (ART), the second largest number of people on ART in any country[2]. Best viewed as a 'subcontinent' with a population of 1.2 billion people inhabiting 29 states and 7 union territories, India has required a coordinated response to HIV, led by the National AIDS Control Organisation (NACO), established in 1986. This response has evolved and intensified over two decades, in four National AIDS Control Programmes. NACP III (2007-12) aimed at halting the HIV epidemic through scaling up Targeted Interventions (TIs) that focused on HIV prevention among key population (KPs) groups with high HIV prevalence. KPs are considered more vulnerable to HIV as drivers of the epidemic and are identified in India as female sex workers, men who have sex with men, transgenders and injecting drug users; and as bridge populations of migrant workers and truckers.

Despite the enormity of the problem, concerted efforts to stem the epidemic has demonstrated significant success. According to N S Kang, Additional Secretary, NACO, *"India has achieved measurable success on various parameters – decline in the number of new infections, decline in prevalence and decline in number of AIDS-related deaths".*[3] India has achieved a 57 percent decline in new HIV infections between 2000 and 2011, and a 29 percent decline in AIDS-related deaths between 2007 and 2011.[4] The major factor contributing to this decline in HIV infections, comes from the country's six high prevalence states where a reduction of 76 percent was noted. Nationally, between 2007 and 2011, HIV prevalence among female sex workers dropped from 5.06 percent to 2.67 percent and from 7.41 percent to 4.43 percent among men who have sex with men[5].

According to UNAIDS, "*India has significantly reversed its AIDS epidemic from 2000 to 2011 due to sustained prevention efforts focusing on key populations, in particular in six higher prevalence states that previously accounted for the bulk of the epidemic. This led to a major reduction in estimated number of new HIV infections at national level*".[6] According to the UN Commission on AIDS (2008), prevention efforts that drastically reduce HIV transmission among and between high risk populations will bring the epidemic under control. Prevention is also seen as an intrinsically cost effective approach where "*USD 1 investment in appropriate prevention can save up to USD 8 in treatment costs for expanding epidemic countries*".[7] NACP in India has consistently allocated between 60 to 70 percent of resources to prevention. In NACP III, 67.2 percent of the budget was earmarked for prevention activities among high risk groups and the general population.[8]

The strategy and plan for NACP IV (2012-2017) was developed through an elaborate consultative approach with all stakeholders. It aims to consolidate the gains of NACP III and accelerate the process of halting and reversing the HIV epidemic in India through a well-defined integration process. NACO has taken cognizance of the emerging challenges and is focusing on region-specific strategies and evidence-based scale up of both its prevention and treatment interventions. India's HIV prevention response represents a fountainhead of innovative service delivery models with an enabling environment that has promoted strong community ownership and rich civil society involvement. This collection presents a broad spectrum of

[1] State HIV Epidemic Fact Sheets, NACO, July 2014
[2] The Gap Report, UNAIDS, 2014
[3] NACO Newsletter, October 2014-March 2015
[4] NACO Annual Report 2013-14. p. 23
[5] NACO Annual Report 2013-14. p. ix
[6] UNAIDS (2015) *Towards a Future without AIDS in India.* http://in.one.un.org/img/uploads/Towards_a_Future_without_AIDS_in_India.pdf
[7] UNAIDS. 2008. *Redefining AIDS in Asia: Crafting an Effective Response – Report of the Commission on AIDS in Asia.* Edited by Marias Hein. New Delhi: Oxford University Press, p. 10.
[8] NACO Annual Report 2011-12

India's best practices in HIV prevention. A best practice is one which has enough evidence of effectiveness; is sufficiently relevant in diverse settings; warrants replication, institutionalisation and mainstreaming across states.

This document presents a snapshot of India's flagship programme on TIs, which facilitates community-based innovations using a peer-led approach. The TIs tailor outreach strategies, use target-specific communication material designed through community involvement, and set up drop-in centres as safe spaces with linkages to service delivery. India's package of prevention practices administered through TIs also includes screening and treatment for sexually transmitted infections (STIs) and Opiod Substitution Therapy (OST) as a harm reduction strategy. India has scaled up these prevention efforts through evidence-based planning where data from mapping of KPs has fed into initiating, implementing and enhancing TI programmes.

A robust MIS at all levels ensures regular data flow and feedback, from sub-district level to national level, and a snapshot of every TI is available from an advanced web-based system at the click of a button. This efficiency in scale up is a direct outcome of NACO's institutional arrangements which promoted one national agency, one national policy and one monitoring system. The administrative and technical support structures at national, state and district levels in combination with decentralisation, has helped enhance quality. This, is turn, has contributed to an increase in programme reach of close to 80% of all key populations. NACO has acknowledged the role and contribution of technical experts, international agencies, related ministries and representatives from civil society in ensuring that the national programme has always delivered the best for people most affected by HIV in India.[9]

The purpose of this collection of best practices is to share successful experiences that can be adapted and replicated in countries which are grappling with the HIV epidemic. Countries in Africa and Asia have similar population groups in terms of vulnerability to HIV; comparable social, cultural, economic, political and religious environments; common risk-taking and health-seeking behaviors, and factors influencing them. There are many countries and regions that can learn from one another in their race against time to meet their targets of '*zero new HIV infections, zero AIDS related deaths*'.

This package of best practices in HIV prevention is the first in a series of compilations of best practices that will extend to other programme areas like treatment, care and support. Intended for policy makers, programme managers, implementers, experts, development partners, health care providers and civil society organisations, this package contains two parts:

- **Part I** has 20 best practices in the form of a two-pager on each practice, which can be referred to independently. However, together all 20 interventions provide a comprehensive picture of India's HIV prevention strategies.
- **Part II** is a CD which contains these 20 practices in soft copy as well as a repository of all references pertaining to each practice. This repository includes strategy papers, operational guidelines, evaluations, annual reports and fact sheets.

While information provided in this compilation may require to be updated periodically, the dissemination of experiences documented is meant to benefit and enhance ongoing and new prevention programmes. Further information on any of the best practices is available on the NACO website[10] and the SHARE online repository.[11] These practices from India can be effectively used by customising them to other national and cultural contexts. India is equally keen to learn from best practices evolved by partnering countries for further scaling up, enhancing quality and ending the epidemic.

[9] NACO Newsletter, April-September 2014
[10] www.naco.gov.in
[11] http://www.s2shareproject.org/Pages/Resources.aspx

1. Targeted Interventions – NACO's Flagship HIV Prevention Programme

Context and Challenges

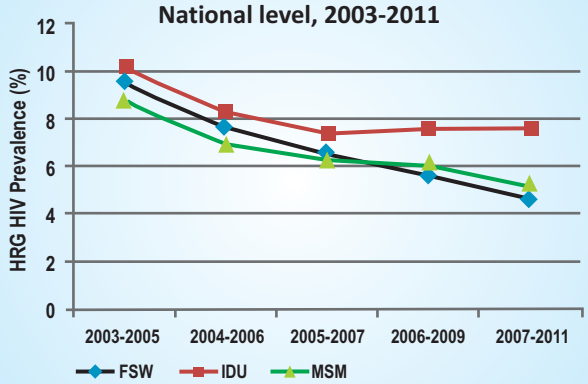
First detected three decades ago, the world continues to see more than 2 million new HIV infections per year.[1] While 87% of HIV transmission in India is related to unprotected sex, not everyone has the same risk of acquiring or transmitting HIV. Most vulnerable to HIV, are those who have a higher number of sexual partners or who share needles or syringes. **Box 1** lists the High Risk Groups (HRGs) and bridge populations who are at risk. Migration and mobility, a feature of bridge populations, is seen as a strong co-factor in accelerating HIV prevalence.

Box 1: Groups covered under 'Targeted Interventions'

- High Risk Groups (HRGs)
  - Female Sex Workers (FSW)
  - Men who have Sex with Men (MSM) including Transgenders (TG)/*Hijras*
  - Injecting Drug Users (IDU)
- Bridge Populations
  - Long Distance Truckers
  - Migrants

The main challenge is that these populations are hidden and extremely difficult to reach. The main goal of the National AIDS Control Programme (NACP) was to ensure the reduction of the rate of new infections. The National AIDS Control Organisation (NACO) continues to focus on saturation of coverage through targeted interventions (TIs) and integrating response with care, support and prevention services. **Figure 1** shows declining rates of prevalence for FSW, MSM and IDU from 2003 to 2011.

Figure 1: HIV Prevalence trends among HRGs at National level, 2003-2011



The Approach: Response and Solutions

Targeted Interventions (TIs) are special programmes devised specifically for HRGs and bridge populations based on evidence. Aimed at Behaviour Change

Communication, TIs promote safer-sex practices, health-seeking behaviour and vulnerability reduction through detection and treatment of sexually transmitted infecti ons and correct and consistent use of condoms. By using a peer-led community-based approach, TIs were able to reach these stigmatised, hidden populations with HRGs themselves taking ownership and spearheading the programme. Mobilisation increased the confidence of these marginalised groups and reduced stigma thus promoting health-seeking behaviour. TIs can keep HIV prevalence low while simultaneously reducing transmission from HRGs to the general population **(Box 2)**.

Box 2: Reasons for HIV Prevention through TIs

- To prevent new infections
- To enable infected HRGs to access treatment
- To use a public health approach with a greater focus on HRGs and bridge populations
- To improve effectiveness of the reach of programmes
- To slow down and eventually stem the epidemic

TIs were scaled up across the country by NACO and State AIDS Control Societies (SACS) in partnership with non-government organisations (NGOs) and community based organisations (CBOs) using standardised guidelines developed by NACO. Standardised unit costs allowed both transparency and replicability on scale. Each TI covered 1,000 members at an average cost of INR 1.8-2.5 million (approximately USD 30,000-42,000) per annum.

The components of TIs are as follows:

1. Behaviour Change Communication (BCC)

BCC involves understanding and assessment of individual and group practices/behaviors which can pose risk of HIV infection. Through sustained BCC, information and education on prevention of HIV/AIDS and STIs, related services are provided using innovative and community friendly communication materials through a peer-led approach. This generates demand for HIV and STI services and helps communities' access free services. Context specific

[1] UNAIDS Factsheet 2014

Figure 2: TI Components

Box 3: Targeted Interventions

A Targeted Intervention is a resource-effective way to implement HIV prevention and care programmes in settings with both low-level and concentrated HIV epidemics.

a) It identifies people within the community most at risk for HIV and STI infection.
b) It targets behaviour and practices, not the identity of the individual HRG
c) It involves increasing service uptake for HRGs and builds ownership to address their issues under the broader frame work of interventions
d) The focus is on using limited resources to maximum benefit.
e) It attempts to remove the barriers to access HIV/AIDS and STI related services through ensuring the availability of quality services and establishing linkage and referral services
f) It addresses issues related to the stigma and discrimination through community mobilisation and enabling environment

activities and counselling (by peers and trained counsellors) are carried out for risk-reduction and service utilisation. Thus TIs promote safe sex /injecting practices, condom use, regular medical check-ups, voluntary testing and treatment.

2. Management of STIs

HRGs are provided regular information by peer educators, outreach workers and counsellors on prevention methods, sensitised on the availability and accessibility of facilities, referred and linked to these facilities. They are encouraged to undergo quarterly medical check-ups through regular follow-up which also includes syphilis screening. Access to STI services is provided through three different approaches, i.e. project based clinics, fixed day–fixed time outreach clinics and referral clinics either with private or government facilities. Colour-coded Kits for STI treatment are provided under Enhanced Syndromic Case Management.

3. Referral and Linkages

Strong coordination mechanisms have been established to strengthen linkages with facilities such as ICTC, DSRC, OST Centre, Detox Centre, etc. This has helped HRGs to access essential services meant to reduce vulnerability. To track the service uptake of HRGs, the referral card system is followed across all TIs. Health care providers at these facilities are adequately capacitated on the perspectives and sensitivity of HRGs.

4. Community Mobilisation

As a key programmatic strategy to address vulnerabilities, community mobilisation (including formation of community committees, holding community events, DIC based activities and so on), motivates and influences norms for safe sexual behaviour. Creating community norms, building community-led service delivery and capacitating CBOs has been an important approach to sustain behaviour change among individual HRGs as well as address structural barriers. This helps build ownership among HRGs who through their CBOs can get involved in programme management, decision making and implementation.

5. Enabling Environment

Creating an enabling environment supports safe behaviour practice among HRGs, reduces stigma and discrimination and improves uptake of services. TIs proactively address structural barriers and advocate with power structures including law enforcers and other stakeholders to ensure a conducive and supportive environment for intervention. Establishment of Crisis Response Systems at the field level and “Safe spaces” in the form of Drop- in-Centres in the TIs helps the intervention and the community to address vulnerabilities.

6. Condom Promotion

Condom programming is initiated at the site level only after understanding various aspects related to condom usage among HRGs. TIs provide information on usage and educate HRGs on acceptability of condoms. Peers and outreach workers calculate the demand for condoms for each HRG at the field level and accordingly ensure adequate stock is made available to HRGs (only male lubricated latex condoms). Social marketing aims to make sure that different brands of condoms (preferred choices) are available at or near pickup points, hotspots, including bars and lodges where sex work takes place.

IDU-TIs:

'Hard Reduction' is the key strategy for intervention among IDUs and their sexual partners, to reduce the risk of acquiring and transmitting HIV. The Needle/Syringe Exchange Programme (NSEP), Abscess Management and Treatment and Opioid Substitution Therapy (OST) are key components in IDU intervention. OST is provided in selected centres either through the IDU-TI or Government health facilities in collaboration with the link IDU-TI. NSEP has been one of the most effective ways of preventing transmission of HIV/AIDS and other blood borne diseases like Hepatitis B and C amongst IDU, with attempts made to provide clean needles and syringes to every IDU for every injecting episode. Doctors and auxiliary nurse midwifes/nurses attached to an IDU TI

treat drug injectors who often get abscesses on their arms or legs, mostly at injection sites, due to unclean and unsafe injection practices. In OST, an unsafe opioid, which requires repeated administration through unsafe/ hazardous routes, is substituted with a medication which is long acting, safer, and medically administered sublingually. This medication helps the client not to experience either withdrawal or euphoria ('high').

Results

India was able to scale-up TIs rapidly to cover 80% of HRGs (especially among FSW and IDU and moving towards saturation among MSM-TG) during NACP III (2007-2012). These TIs have been implemented in 1,873 specific geographical pockets[2] across India by NACO in collaboration with NGOs and CBOs. TIs have reached 868,000 FSW, 313,000 MSM, 70,000 TG, 177,000 IDU, 7.2 million of the bridge populations and 2 million migrants and truckers **(Figure 3).**

Thus in a period of ten years NACO's flagship prevention programme, Targeted Interventions, was able to reduce new infections by 57%[3] **(Figure 4).**

Citing the Asia Epidemic Model, the Commission on AIDS in Asia highlights the cost-effectiveness of TIs that focus on preventing HIV among sex workers and their clients.[4] For the same amount of money spent on universal precautions, TIs prevent 7,000 times more new infections.

Figure 3: Coverage of Core HRG (FSW, MSM, TG, IDU) during 2013-2014 (N=1,00,000)

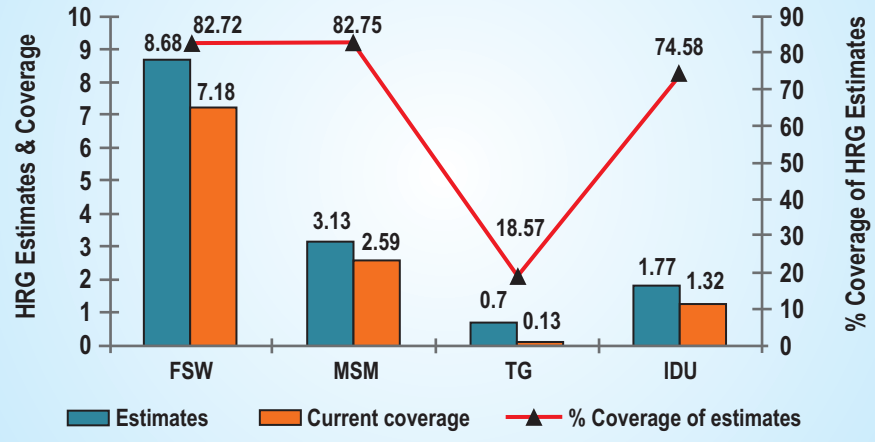
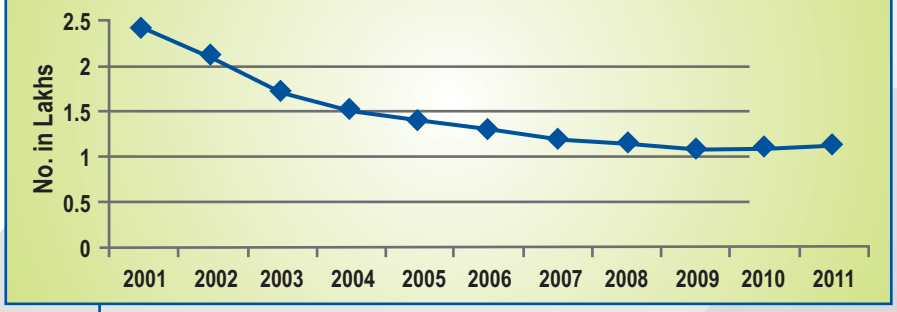


Figure 4: 57% Reduction in New Infection (2000-2011) with Scale-up of Prevention Strategies



[2] NACO Annual Report 2013-14. p.23
[3] NACO Annual Report 2013-14. p.ix
[4] UNAIDS. 2008. *Report of the Commission on AIDS in Asia.* Edited by Marias Hein. p.9

2. Hot Spot Analysis by Peers

Context and Challenges

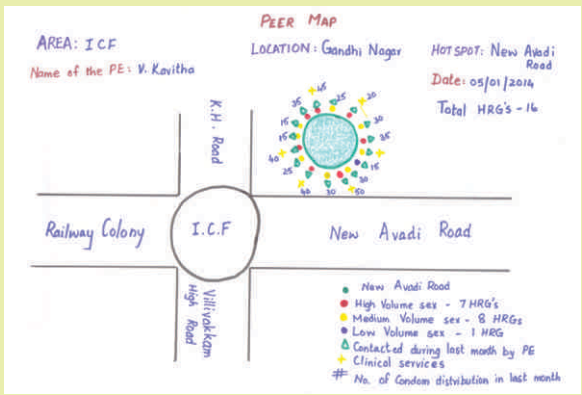
In 2007, the National AIDS Control Organisation (NACO) found that the saturation and coverage of services provided to High Risk Groups (HRGs) was low. While HRGs are the most prone to contracting and transmitting HIV, they also have the least access to prevention, care and treatment services. HRGs tend to remain hidden as their behaviour is often stigmatised, making it hard for agencies to efficiently plan for the quantum of services required. In order to put in place appropriate and effective interventions, it was important to identify specific geographical areas where concentrated groups of HRGs were present.

The Approach: Response and Solutions

In 2007, strategies were developed for setting up Targeted Intervention (TI) programmes which included:

- **Mapping of HRGs** by communities to determine areas of concentration or the location of hot spots. This collects essential standardised information comparable across TIs which feeds into the Strategic Information Management Systems (SIMS).
- **Grading** by the type and scale of HRGs frequenting these spots.
- **Micro-planning** was done based on evidence to create better access to services.

Figure 1: Peer Map



The entire process was decentralised whereby communities took ownership and managed the process of identification and grading of hot spots.

A geographical area demarcated by a definite boundary (such as a town, city or a village) is referred to as a 'site' and areas within a site where there are significant concentrations of HRGs are referred to as 'hot spots'. Within hot spots, HRGs may solicit, cruise, interact with other HRG members, have sex or share injecting drugs. The main aim of hot spot analysis is to effectively and quickly reach HRGs with information and services and to begin the process of mobilising HRGs for HIV and Sexually Transmitted Infection prevention.

To improve both outreach and planning, communities were given the task of mapping these geographical locations where sex or sex work is solicited and where people inject drugs. Mapping under NACP III refers to three exercises: 1. Review of secondary data; 2. `Broad mapping' to estimate size, identify HRG typology and locations of risk; and 3. `Site assessment' to derive basic insights into factors that make HRGs particularly vulnerable to HIV, and to initiate interventions.

When peer educators are first trained on micro-planning, they draw a simple pictorial representation of the areas where high risk behaviour is exhibited by HRGs. The hot spot map includes streets, buildings, cinemas, police stations, railway, bus, and train stations, as well as places where condoms are available. The peer educator identifies the number and location of HRGs within the hot spot. Information on the map may be colour-coded for typology (codes for brothel-based sex workers, street-based sex workers, etc.) or risk levels of different HRGs (see **Figure 1**). Peer educators revise these maps (usually every six months) to track changes, such as new HRGs or those who have left the area.

Process of Mapping

Hot spot mapping is done by getting information from multiple sources about the hot spot such as:

1. **Primary Key Informants:** These are members of HRGs and their sexual partners, such as sex workers and their clients or people who inject drugs and their sexual partners.

2. **Secondary Key Informants:** These are individuals who are in regular contact with HRGs linked to their occupational or sex lives or addiction practices. For example, hotel workers, suppliers of injecting drugs and equipment, shopkeepers near risk sites, drivers plying routes near hot spots, agents, brokers, pimps and so on.

3. **Tertiary Key Informants:** These are people with a good idea about HRGs at town or district levels, such as Non Governmental Organisations (NGOs), government officials, pharmacy owners or local journalists.

It is advisable **not** to consult groups that are known to have adversarial relationships with particular HRGs, such as rowdies and *goondas*, as this might jeopardise their trust in the mapping exercise or cause them actual harm. The mapping process is now universally implemented across all TIs and is a pre-requisite for planning and delivery of services within a TI.

Results

Evidence-Based Service Delivery: Hot spot grading provides the information base and comparable data for the TI programme across the nation. All peer-led outreach planning build on information gathered from hot spot mapping. It helps deliver a standardised service package which in turn, ensures a minimum quality of services. Empowering peers and working with NGOs to be more supportive in performing basic outreach duties are the first steps towards peers gaining ownership over the programme. This was enhanced considerably by hot spot grading which informs micro-planning, and is a tool that enables peers to understand their entire case load at a glance. Hot spot grading allows peer educators to prioritise outreach and review progress of the community they work with.

Risk Assessment of HRGs: Hot spot grading is instrumental in obtaining data on risk behaviour patterns for different typologies of HRGs. This helps programmes address specific needs of members. During incidents of violence faced by HRGs or in the case of alcohol abuse, peer educators are often involved in problem solving. They then add new data points, such as indicators on violence or alcoholism among clients, in hot spot maps which are then entered in the reporting systems. It has been observed that there is a significant rise in condom distribution and clinic attendance after peer led micro-planning is introduced into a TI programme thus reducing their vulnerability to HIV.[1]

Mapping as an Identification Tool: As HRGs themselves are recruited to conduct mapping, results tend to be closer to reality. Since mapping involves getting people to identify themselves and provide sensitive information about their sexual behaviour, HRG members share information without fear or prejudice if solicited by their peers, who are acceptable and credible to them.[2]

Experiences and Lessons Learnt

Hot spot grading helps systematic compilation of available data for a site, identification of information gaps for effective strategic planning locally, and development of a framework for re-prioritisation of hot spots and delivery of services under a TI.

Constitution of mapping teams should include representation from all subcategories of HRGs in a site. For instance, brothel-based sex workers, whose operations are restricted to a particular brothel in a town, may not know where street-based sex workers solicit their clients. Similarly a *hijra* (transgender) may not necessarily be able to relate to Men who have Sex with Men.

Community ownership: Micro-planning using processes like hot spot grading encourages active involvement and decision-making by peer educators in all aspects of the programme. Over time, this leads to empowered and informed peer educators with a strong level of ownership - an important ingredient for community-based organisations (CBOs) as they become independent.[3] Committed and dedicated peer educators are powerful role models, who sustain behaviour change within the community, as well as advocate for their rights.

[1] Avahan, 2009. Managing HIV Prevention from the Ground Up: Avahan's Experience with Peer Led Outreach at Scale in India.
[2] NACO, 2007. Targeted Intervention under NACP III: Core High Risk Groups - Operational Guidelines.
[3] Futures Group, 2013. Micro-Planning in Peer Led Outreach Programmes - A Handbook.

3. Management Information Systems (MIS) at the Targeted Intervention Level

Box 1: Activities of MIS in HIV Prevention

- Data collection occurs at TI level
- Data analysis takes place at TI, DAPCU and state levels
- The epidemic's magnitude and trajectory is tracked at state and national levels
- Informed policy decision making
- Periodical tracking of programme performance and HRG behavioural change

Box 2: Standardised MIS Formats and Registers Maintained in a Static TI Clinic

- Counselling Register (maintained by counsellors on counselling sessions in TIs)
- Daily Clinic Summary Sheet (maintained daily by doctors on patients)
- Network Clinic Card (tracking doctor's findings and prescriptions)
- Medicine Stock Register and Patient-wise Medicine Distribution Register
- Referral Slip (filled in triplicate by Out-Reach Worker/ counsellor/doctor for referral services)
- Referral Register (for Lab tests, Integrated Counselling and Testing Centre, Prevention of Parent to Child Transmission, Anti-Retroviral Therapy, etc.)

Context and Challenges

Timely and accurate information is crucial for planning, implementation and to track progress of an evidence-based programme. In a complex country like India, the challenges lie not only in accurately collating data which is collected by different staff at the Targeted Intervention (TI) level, but also in ensuring timely flow of information from the grassroots all the way up to national level for policy decision making. Further, there was no common understanding on the indicators in use as well as those reported across TIs in a given state and also across states.

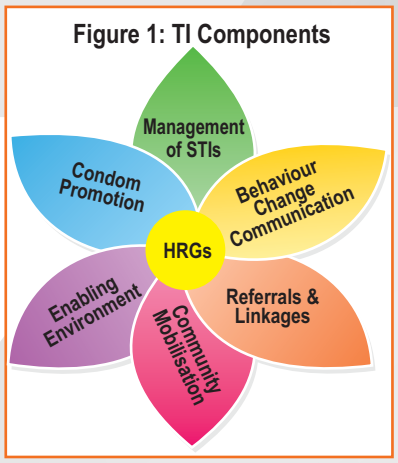
Before the third phase of the National AIDS Control Programme (NACP), grassroots peer workers, outreach workers, clinic and programme staff collected data in countless paper-based forms on a daily, weekly and monthly basis. Individual tracking and monitoring systems for service delivery at the TI and State AIDS Control Society (SACS) level were not in place, making it difficult to track TI performance. With no clarity or expectation from NACP, each state developed and used its own formats to report state-specific indicators. Staff in a TI were unaware of their roles in information collection and reporting. The lack of structured documentation to track historical data and indicators resulted in incomplete data collection, reporting, inaccurate verification and validation mechanisms, delays in information sharing and feedback and lack of supportive supervision or course correction for non-performing TIs. This led to delays, quality and non-availability of data which affected evidence-based planning and timely decision-making.

To address these shortcomings, National AIDS Control Organisation (NACO) set up institutional mechanisms and capacities at the national, state, district and reporting unit (RU) for Monitoring and Evaluation (M&E) of programmes. This, along with periodic monitoring of behaviour change of High Risk Groups (HRGs), provided direction to planning and implementation at the TI level.

The Approach: Response and Solutions

Today, India's response to the evolving HIV epidemic is largely based on evidence generated from multiple sources such as HIV surveillance, programme data, and research studies. Activities undertaken to improve the MIS include: a) development of standardised data collection tools with common indicators, to ensure comparability; b) clear instructions on usage; c) defining role clarity for staff on completing reporting formats; d) reviewing and aligning indicators with NACP III objectives; e) developing computerised tracking systems for service delivery to individuals; f) computerising data collection and reporting formats. Every TI which is a reporting unit at the sub-district level refers to a 'Field Based Guide for Quality Data Collection and Monitoring'. **Box 2** lists data collection tools within a TI clinic programme.

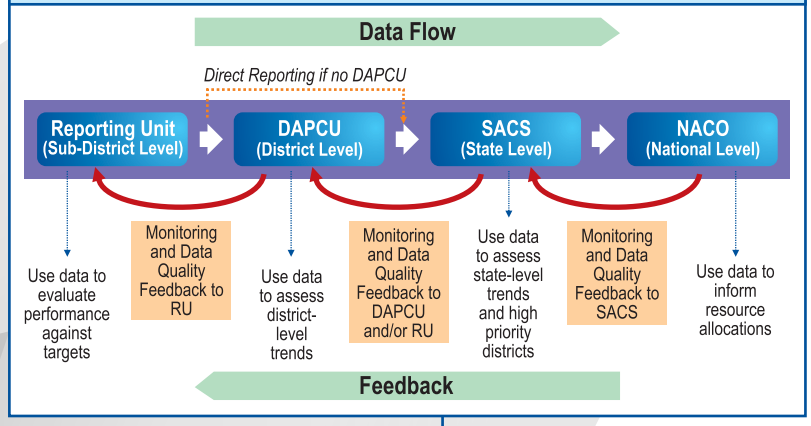
Figure 1: TI Components



The components of a TI monitored under NACP III are outreach, Behaviour Change Communication, creating an enabling environment, management of sexually transmitted infection, commodity provision (condoms, needles and syringes) and referrals and linkages to other health services (see **Figure 1**).

Regular flow of information from the TI at the sub-district level all the way to NACO at the national level is critical to monitor and support the TI to achieve its targets. See **Figure 2** for data flow and feedback. Data in a TI is compiled, collated, checked for completeness and

Figure 2: Data Flow and Feedback between TI and NACO



accuracy, and then reported in a structured Strategic Information Management System (SIMS). The Programme Manager in the TI is responsible for documentation and data compilation based on the standard Monthly Indicator Reporting Format (an Excel spreadsheet), which is forwarded to the District AIDS Prevention and Control Unit (DAPCU). At the district level, data sent by TIs is scrutinised for completeness and correctness of reporting. DAPCU reports to SACS and the final state level information is compiled and sent to the national level. NACO provides feedback to SACS on data quality and uses information for decision-making on establishing and emphasising key programme parameters for HIV prevention, control and resource allocation.

An advanced web-based application with a central server and sophisticated tools for data analysis and integration from different data sources/platforms, SIMS provides differential data management rights to various users with both online and offline modes of data entry. Once data is entered at the RU level, all higher levels can view the data in real time. SIMS ensures data quality checks across various reporting levels and generates basic to advance reports using analytic tools.

The Technical Support Unit (TSU) provides handholding support, to TIs every month to improve quality of data and performance through gap analysis. TSUs also provide technical support to SACS on key aspects of implementation by closely monitoring activities of TIs, providing supportive supervision and regular on-site mentoring.

Capturing information on these components through defined indicators is instrumental in generating a comprehensive depiction of the ongoing intervention.[1] 'One data set' ensures information reported to NACO is standardised.

Box 3: Impact of the MIS

1. **Measuring achievement** in terms of targets achieved
2. **Comparing results** across TIs, districts, states
3. **Assessing progress** in terms of objectives met
4. **Identifying strength and weakness**, in terms of where the TI needs improvement and how it can be done
5. **Checking effectiveness** in terms of the project's impact and if the original objectives are still relevant
6. **Sharing experiences** so that information can prevent loopholes or encourage positive approaches

Results

Having a structured system in place to ensure correct and complete MIS at TI level has resulted in:

1. Consistent reporting of over 90% every month since 2012.
2. Timely scaling-up of TIs towards saturated coverage of HRGs.
3. Tracking non-reporting TIs and providing supportive supervision.
4. Tracking TI performance with timely feedback on monthly basis.
5. Improving the quality of services provided to HRGs.
6. Comparison of standard indicator results across interventions and states for timely intervention to address gaps.

The SIMS provides a clear bird's eye view of each of the 1,873 TIs (with Female Sex Workers, Men who have Sex with Men, Transgenders, Injecting Drug Users, Migrants and Truckers) in India as recorded in March 2014. TSU assessments suggest that the performance of TIs nationwide have improved remarkably and Female Sex Workers coverage against estimates has already crossed 90%.[2]

Box 3 shows the impact of the MIS in terms of providing evidence of performance that can be compared across TIs. Successful scale-up of TIs and saturated coverage of HRGs is a direct outcome of quality data analysis from the MIS.

Experiences and Lessons Learned

A structured MIS and a web-based integrated data management system offers the opportunity to improve programme reporting, data quality and to allow simultaneous use at all levels of programme management. Monitoring systems need to be relevant at the field level and must measure achievement, not just effort. Tools designed are not rigid and can be adapted based on community involvement in designing and redesigning of these tools. The in-depth 'gap analysis' helps link back to micro planning at the foot soldier level – namely the peer worker.

[1] NACO Annual Report 2013-14
[2] *ibid*, p. 19.

4. Specific Strategies for Different Typologies of Female Sex Workers

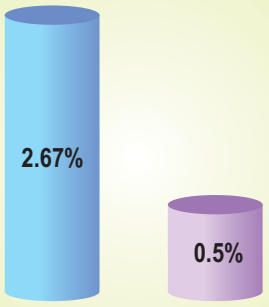
Box 1: Typologies of FSW

1. **Street-based sex workers:** solicit clients on the street or in public places such as parks, railway stations, bus stands, markets and cinema halls. They may live in a brothel and may entertain their clients in a lodge, car, truck, hotel room, at the client's home, in a cinema or in a public place
2. **Brothel-based sex workers:** have clients who contact them in recognised brothels (buildings or residences where people from outside the sex trade know sex workers live and work). Typically, a brothel is a place where a group of sex workers is managed by a 'madam' or an agent
3. **Lodge-based sex workers:** reside in a lodge (a small hotel) and their clients are contracted by the lodge owner, manager or any other employee of the lodge on the basis of profit sharing
4. ***Dhaba*-based sex workers:** have truckers and other motorists as their main clients and are based at *dhabas* (roadside resting places) or country motels
5. **Home-based or 'secret' sex workers:** operate usually from their homes, contacting their clients on the phone, through word of mouth or via middle-men (e.g. auto drivers). Generally, they are not known to be working as sex workers in their neighbourhood
6. **Highway-based sex workers**: are those who recruit their clents from highways, usually from among long distance truck drivers

Context and Challenges

In India, HIV transmission is mostly heterosexual, and evidence indicates that a substantial proportion relates to sexual networks including Female Sex Workers (FSW). Studies have shown a great heterogeneity in prevalence rates across Indian surveys conducted among FSW. HIV prevalence among FSW in India is 2.67%, which is much higher than that of the general population (<0.5% as indicated by ANC data) (**Chart 1**).[1]

Chart 1: HIV Prevalence



Sex work typologies (classification into types or categories) play an extremely important role in India's National AIDS Control Programme (NACO) HIV programming and research. The national typology developed in 2007 for Targeted Intervention (TI) operational guidelines for core groups is comprehensive and programmatically appropriate. Based on where they solicit clients and not where they live or actually entertain the clients, there are six categories of sex workers (**Box 1**). Programmes that attempt to reach sex workers in their residences can be problematic, especially if she is 'anonymous' at her home and practices without the knowledge of her family.[2]

NACO maps FSW prior to programme implementation, to collect information on the type of sex work practised in the area. Historically it was found that common approaches are not applicable to all typologies. Challenges emerged because certain types of sex workers are more difficult to reach, while others with higher numbers of clients represent higher risk behaviour. Each type therefore merits a different strategy.

The Approach: Response and Solutions

Designing appropriate, large scale interventions targeting FSW required not only planning appropriate service provision, but also effectively identifying and characterising sex work locations, particularly the size and spread of this population. Understanding the distribution and organisation of sex work is crucial to developing and implementing evidence-based HIV prevention and treatment programmes. Due to behavioural differences, such as client volume and condom use, vulnerabilities of FSW vary requiring different interventions.

As the basic concept of 'scaling up' involves increasing the proportion of the target populations receiving a defined set of programmes and services, mapping is key to determine the target population size and locations. The mapping of these risk indicators informs the design of outreach and service delivery strategies (**Box 2**). Surveys take into account the FSW typology, which is an important independent variable in most analyses on sex work, as related to Sexually Transmitted Infections (STI)/HIV risk or other issues.

[1] NACO Annual Report 2013-14, p.ix
[2] NACO, 2007. Targeted Interventions Under NACP III: Operational Guidelines – Volume I: Core High Risk Groups. p10

During National AIDS Control Programme (NACP) III, some successful interventions with different FSW typologies in high-prevalence states demonstrated more sustainable prevention efforts. TIs were synchronised with specific needs of community members and tailored specifically for their unique contexts and typologies. There was also a strong element of community management highlighted in **Box 3**.[3]

Box 2: Strategies Tailored to Different Types of FSW

Brothel-based: Using a rights-based approach combined with financial security and an enabling environment allows safer sex practices

Street-based: Outreach targeting public/street-based sex workers occurs during solicitation times and includes prevention messages and condom distribution

Home-based FSW including *Devadasis*: Peer-based approaches have been the most successful way to identify and reach out to home-based hidden sex workers

Results

Tremendous progress has been made under NACP III in saturating the coverage of FSW from 22.3% in 2007 to 82.7% in 2014.[4] Considerable declines in HIV prevalence have been recorded among FSW at the national level from 5.06% in 2007 to 2.67% in 2011.[5] Increased treatment coupled with enhanced access to services, better HIV testing and STI service infrastructure, and higher condom use were key factors. Customised strategies for different FSW typologies further allowed for better outreach, tactical planning and far more effective service delivery.

- *Impact on Street-based FSW*: Increased exposure to peer educators through outreach during solicitation time has resulted in consistent condom use among FSW with up to 75% of their regular clients and 72% of their occasional clients.
- *Impact on Brothel-based FSW:* HIV and STI prevalence in the Kolkata area remains below 10% compared to 50% elsewhere. Through collectivisation and improving financial security, the project has enabled FSW to dramatically increase control over their bodies, living and working conditions.
- *Impact on Home-based FSW:* By connecting with hard-to-reach groups on the ground, peer outreach workers improved uptake of clinical and social support services.

Box 3: Building Financial Security for Sex Workers

An effective intervention which has combined the positive impacts of economic empowerment and collectivisation is a cooperative society in a red light area. It was started in 1995 under the guidance of a sex workers' collective. The programme was able to successfully create an enabling environment where members led from the front and were able to enforce the use of condoms by their clients. In short, providing sex workers with a secure financial future enables them to practice safer sex.

Experiences and Lessons Learnt

A multi-sectoral response to HIV comprehensively addresses risks and vulnerabilities by facilitating the following:

- Creation of enabling environments reduces barriers to prevention, treatment with care and facilitates access to services for different types of FSW.
- Addressing structural barriers of different types of sex workers helps them access social entitlements, which in turn, reduces their vulnerability to HIV.

[3] DMSC, TAAH, 2007. Meeting community needs for HIV prevention and more: Inter-sectoral action for health in the Sonagachi red-light area of Kolkata, p.2.
[4] NACO Annual Report 2013-14, p.x
[5] NACP IV Strategy Document, 2012. p.5

5. Line Listing and Unique Identification Systems in Targeted Interventions

Context and Challenges

Initially, the Targeted Intervention (TI) coverage was based on geographical mapping data, which provided approximate numbers of High Risk Groups (HRGs) in specified zones, disaggregated by typology and the sites or 'hot spots' they frequented. The challenges here, related to identifying and registering individual members into TIs. This was because HRGs of Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TG) and Injecting Drug Users (IDU) who were contacted by peer and outreach workers, did not want to be formally registered as they wanted personal information like name, location and even typology to be kept confidential. Some registered members who were not contactable or not regularly accessing services cited mobility, migration and personal reasons as causes. This led to problems such as under-registration of members in the TI, registered members being unreachable for follow-up services, or even dropping out altogether. Those who were easy to access, received services routinely, while inaccessible members who most needed help were left out. There were also issues of duplication in reporting within a TI and between projects in adjoining districts.

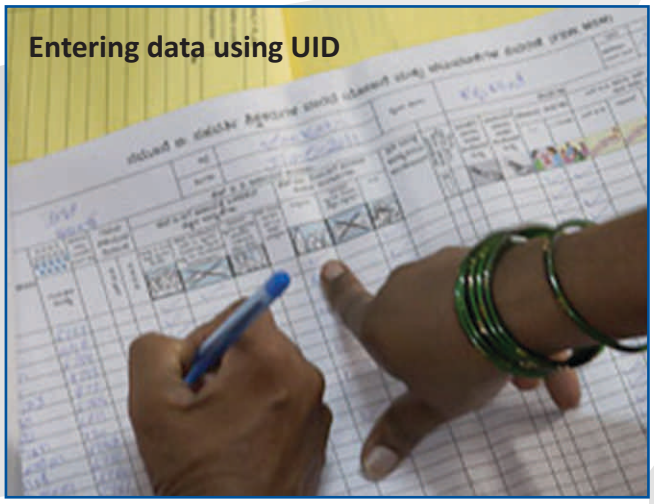


Photo: Aneka

To overcome these challenges, it became clear that every TI needed a system that identified individual members, while simultaneously protecting confidential information. Additionally, each member who accessed services, needed to be tracked regularly. Only then would there be an effective coverage of HIV prevention services for HRGs.

Tis have been scaled up across the country for high risk and stigmatised populations to have equitable access to a range of HIV prevention services including behaviour change communication, condoms, safe needles and syringes (for IDU), Sexually Transmitted Infections (STI) treatment, referrals for HIV testing and Anti-Retroviral Therapy (ART). Using Line Listing and Unique Identification (UID), the National AIDS Control Programme (NACP) focuses on improving health-seeking behaviour of HRGs, as well as reducing their risk of contracting STI and HIV infections.[1]

The Approach: Response and Solutions

While establishing a comprehensive Management Information Systems (MIS) for TIs, NACP III developed standardised formats and designed data collection tools for detailed documentation while maintaining individual confidentiality of HRG members. Through a consultative process, tools and methods were developed that would be accepted by HRGs and ensure individual service tracking with follow up on referral services. Staff of all TIs were trained to use these piloted and standardised tools as part of outreach planning and monitoring.

Registration Format: This is filled by the Outreach Worker (ORW) after an individual HRG is identified by a peer worker. It collects comprehensive information of the member (name, age, contact details, category/typology, sub-category/typology and location), with date of registration. This confidential form is kept in safe custody by the MIS officer or Programme Manager at TI level. Each HRG is given a coded UID number for tracking and ensuring that they access services regularly.

UID Number: MIS officers assign a fifteen digit UID number to individual FSW, MSM-TG and IDU. Using this UID number instead of a name protects confidentiality while also identifying the district and sub-district (**Box 1** provides information on the details coded into a UID).

Box 1: Assigning UID Numbers in a TI

STATE CODE 2 digit	District code 2 digit	Town Code 3 digit	TI Code 3 digit	HRG Category 1 digit	HRG ID code 4 digit

A master list of names for each HRG was maintained securely at the implementing office or at the intervention level, and the only identifiers used on the peer worker's outreach forms were HRG 4 digit ID codes and small stickers with pictorial symbols. The symbols often suggested a feature or personality characteristic of the member to help the peer worker identify individual members of HRGs who were, in a sense, their responsibility.

HRG Master Register: This computerised sheet using an excel format is also called the 'Master List'. Information from all individual registration forms is entered into the Computerised

[1] NACO Annual Report 2013-14

MIS (CMIS/SIMS) location-wise (sites/hot spots) to provide a computerised data bank of HRG members' details within a TI's implementation area. This Master Register is a restricted document and TI staff are sensitised and trained to maintain strict confidentiality on individual identities.

Line Lists: Sub-sets of the Master List generated from the computer allow each peer worker to track service delivery to individual HRG members (Individual Service Tracking). Each Line List contains those members who are the responsibility of one peer worker in an allocated area. This not only helps the peer worker to plan and improve outreach by contacting and motivating members to access services, it also makes the documentation process simple. Line Lists are updated daily. In addition to individuals that the TI regularly provides services to or contacts, it registers new members and contacts added in the last six months. It regularly removes the names of those registered and contacted in the past but who could not be reached in the last six months. Therefore, updated Line Lists show all HRG members who are currently under the coverage of a TI. **Box 2** explains how Line Lists with UID are used to implement and monitor the clinic programme component in a TI.

Box 2: Using UID and Line Lists in Clinics

In a TI for FSW all peer workers reporting to the ORW have a copy of the Line Lists with the UID numbers of FSW. Each peer worker contacts individual FSW in their Line List as part of regular outreach, distributes condoms and motivates first timers to visit the clinic. She/he also reminds members who are due for their quarterly Regular Medical Check-up or follow up of STI treatment, to access services on specified dates.

Every week, the respective ORWs go to clinics linked with the TI programme and gather copies of the Patient Cards and Referral Slips of HRG members who accessed services.

The clinic counsellor uses Line Lists, Patient Cards and Referral Slips to tabulate the information related to clinic services provided and record all referrals made for HIV testing, ART centres or any other facility.

These weekly records are fed into the MIS in the TI to capture month-wise programme coverage.

Advantages of using these regularly updated tools and processes are:

- Each HRG will have a unique identification number.
- At any given point of time, every peer worker in a TI has an updated confidential list of HRG members registered in the programme along with the services being received by each.
- A list of members by site/hot spot can be retrieved quickly and easily without going through the physical registration forms.
- A clear picture is available of the numbers and typologies of HRGs in each site/hot spot, as well as the regularity/irregularity with which they are accessing services.
- Updated lists also reveal the number of members who have dropped out of the programme and from which sites. It also tracks HRGs who have returned to the programme.

The UID system is also used to track the service delivery provided by peer workers, to assess their performance.

Results

1. The Master Register and Line Listing validates and authenticates the UID numbers and further links to Individual Service Tracking.
2. Line listing is implemented across all TIs in the country to provide uniform and reliable data differentiating cumulative services and individual services provided in each and every financial year.
3. Performance-based payments ensure no duplication and cost-effective outreach for the national programme without any confusion on the number of individuals reached and services provided to each individual.

Individual Service Tracking using Line Lists with UID numbers has made it possible to capture accurate programme coverage data in TIs at the implementation level, while ensuring individual anonymity of HRG members. This has led to increase in demand for and access to HIV prevention services, sharing of information and co-ordination between service delivery points and strengthened focus on high quality programming. For instance, using this data, TANSACS along with different donors and key stakeholders piloted a *Master Health Check-up* programme to provide comprehensive health services for community members in Tamil Nadu.

Apart from increasing service coverage, tracking also provides information on ORWs and peer workers who are responsible for every HRG member in a TI. Data is analysed for future outreach planning and strengthening evidence-based planning. This leads to improved service delivery such as distribution against demand of condoms, needles, and syringes, uptake of Opioid Substitution Therapy, due/overdue Regular Medical Check-ups, referrals to Integrated Counselling and Testing Centres, TB/Syphilis Screening tests and linkages to ART. After proving to be successful in tracking service delivery for FSW, MSM and IDU, similar systems are now being piloted for Migrant TIs under NACP IV.

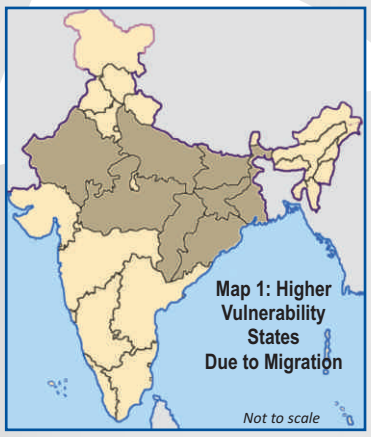
Experiences and Lessons Learnt

It is important to make one staff person in a TI responsible for assigning UID numbers and keeping a master list. This avoids the possibility of issuing duplicate identity cards for one member or for issuing the same UID to members with similar names. Confidentiality thus becomes key to ensuring members of HRGs access services and increase in coverage.

6. Tailoring HIV Prevention Interventions to Migrant Needs

Context and Challenges

India, home to the third highest number of HIV positive people in the world, is characterised by widespread and fluid migration and mobility. More than two million Indians do not live in the place of their birth.[1] A larger proportion of migrants have been found to be infected with HIV compared to the general population. Not only are sexually active male migrants at risk of contracting HIV when away from home, but their wives are equally at risk when they return home. HIV prevalence among single male migrants was 3.6% in Odisha, 3% in Maharashtra and 2.42% in West Bengal in 2009.[2] **Box 1** presents criteria to assess HIV vulnerability among male migrants. At the beginning of the third phase (2007-2012) of the National AIDS Control Programme (NACP III), Targeted Interventions (TIs) were largely planned at urban work locations (destination areas) to lower HIV risk among males. No interventions were implemented in source areas either for returnee migrants or their vulnerable families. Based on evidence of vulnerability at source, role of returnee migrants, rising infections and to ensure continuum of care, support and prevention services when migrants are in transit, the migration strategy was revised. The programme is now implemented in all three areas namely source, transit and destination, catering to both male and female migrants and their families.



Box 1: Criteria to assess HIV Vulnerability among Male Migrants

- Intersection with sexual networks of High Risk Groups (HRGs) (FSW, MSM, Transgender)
- Pattern, degree and duration of mobility and migration
- Age (15-49 years)
- Whether moving alone or with family
- Route of migration
- Destination (high HIV prevalence areas)

The Approach: Response and Solutions

To fulfil its objective of reducing new HIV infections by 50% (from the 2007 baseline), the NACP IV Strategy Document prioritised the provision of a package of prevention services for migrant populations at source, transit and destination points. A total of 122 districts with high out migration across 11 states were identified for community level migrant interventions.[3] The key strategies include:

a) *Working with migrants and other vulnerable groups:* Men or women, who migrate alone (without families), from rural to urban destinations for employment are prioritised for prevention interventions. Trafficked women and detained immigrants are other groups considered vulnerable to HIV.

b) *Assisting safe migration:* Migration kits containing booklets on services available in major destinations along with condoms and items of daily utility are distributed to migrants free of charge in migrant information centres situated around bus and train stations at source areas. This reinforces HIV prevention messages and encourages out-going migrants to seek HIV related services at destination points**. Box 2** provides details of the intervention package for high-risk migrants.

Box 2: Intervention Package for Migrants in TIs

Outreach and Communication: This includes outreach, Behaviour Change Communication and large group activities (such as street theatre and games)

Services: This include condom promotion, health check-ups, management of Sexually Transmitted Infections (STI), Reproductive Tract Infections (RTI), linkages to STI and other health services such as Integrated Counselling and Testing Centres, Anti-Retroviral Treatment, drug/alcohol de-addiction as well as strong referral and follow up systems

Enabling Environment: This includes advocacy with key stakeholders, power structures and linkages with other programmes and entitlements

c) *Advocating for corporate HIV interventions for informal labourers*: Employer Led Models (ELM) of HIV interventions are implemented by industries and corporates, who employ significant numbers of migrants and truckers. State AIDS Control Societies (SACS) assist government departments, private sector, employers' and workers' organisations to develop workplace policies, based on the 'National Policy on HIV/AIDS and the World of Work' on how to implement the ELM approach.

Models of HIV prevention interventions (see **Figure 1**) for migrants are categorised as:

1) Targeted Interventions at Destination: In locations with high volumes of migrants (between 10,000 to 15,000 high risk migrants in any given year), migrant TIs are planned and executed mainly through Non Governmental Organisations (NGOs). Other stakeholders involved in implementation include contractors, trade unions, market committees, company partners and industry management.

2) Transit Point Interventions: The national programme reaches out to migrants at transit points, to ensure reinforcement of messages on risk and vulnerability reduction through different service delivery models such as:

• *Direct Interventions:* In high volume transit corridors, NGOs are

[1] Saggurti, Niranjan et al. 2008.
[2] Source: HIV Sentinel Surveillance 2012-13- A Technical Brief, NACO
[3] NACO, Annual Report 2012-13

Figure 1: Migrant Intervention Strategy

made responsible for intensified intervention services specifically targeting migrant populations.

- *Mainstreamed Interventions:* Additional resources are given to existing TIs working with HRGs in the transit areas, to reach out to high risk migrants with a package of services.
- *Linkages with other Programmes and Departments:* In low volume corridors, low intensity intervention models through linkages with existing programmes like National Health Mission (NHM), government health delivery structures, labour welfare and transport departments anchor a minimum package of services for HIV prevention.

3) Interventions at Source: TIs reach out to migrants (potential, outgoing and returnee), their spouses and the community in which they live, focusing on both risk and vulnerability reduction. Equipped beforehand with accurate HIV knowledge and information, a migrant would be more likely to make safe choices, and thus be at lower risk for HIV even at destination points. An important component here is outreach to women who remain behind while their husbands or sexual partners migrate. **Box 3** illustrates an example of an intervention in a source area for families of migrants. Such programmes are implemented either through

Box 3: Ganjam - Male Migration and HIV Prevalence among Pregnant Women

Ganjam is identified as one of the 14 most critical HIV districts, containing 35.9% of the total People Living with HIV in Odisha. Men migrate predominantly to cities in states with high HIV prevalence (Surat in Gujarat; Mumbai and Thane in Maharashtra). HIV infection among pregnant women attending antenatal care clinics was alarming and significant association was inferred between spousal migration and women's HIV status. Ganjam district was therefore prioritised for migrant interventions at source under NACP III and IV.

State Implementing Agencies which are independent NGOs supported by NACO through SACS or through the Link Worker Scheme.

NACO organises outreach health camps and communication activities in source states, especially when migrants return home during festivals such as Dussehra, Deepawali and Eid. They provide health services such as free health check-ups, treatment of STI/RTIs, common ailments, HIV testing and counselling on prevention and treatment of HIV/AIDS. In the source states of Bihar, Chhattisgarh, Jharkhand, Uttar Pradesh, Rajasthan, Odisha, Madhya Pradesh and West Bengal, 1,278 camps were conducted in 108 districts. Information, education and communication materials are developed in different state languages. Mass and folk media campaigns and ground level activities are conducted to reach migrants. NACO has initiated modelling of migrant interventions across two important 'corridors' of high out migration and is piloting a web-enabled tracking system to ensure continuity of services. Technical Support Units provide technical assistance at district and state level in mentoring and monitoring of migrant interventions.

Results

Led by NACO, SACS implemented 289 TIs at migrant destinations reaching out to 2.9 million high-risk migrants in 2014.[4] Such TIs improve knowledge about HIV prevention, reduce risky behaviour and enhance utilisation of STI services and voluntary HIV testing. Inter-state coordination, integration with health systems and other government departments, involvement of industry managements and collaboration with voluntary groups, civil society networks, women's groups and youth clubs has strengthened creation of enabling environments for migrant families.

Of the 2.92 lakh people who were educated on HIV/AIDS and treated for STIs and general ailments in the health camps, around 43.8% availed voluntary counselling and testing for HIV. About 7.8 lakh migrants and their spouses were reached through 64,320 outreach sessions till March 2014.[5]

The HIV Sentinel Surveillance data showed considerable decline in HIV prevalence among male migrants from a high 3.61% in 2007 to 0.99% in 2011[6] and this has contributed to reducing new HIV infections in India by 57%.

Experiences and Lessons Learnt

India has learnt that multi-point interventions at workplace destination, source and transit points are vital to reduce risk and vulnerability among migrant families. Inter-state coordination is crucial for migrant interventions to succeed. Innovations and partnerships at source, destination and transit points are important features of NACP III and IV for HIV prevention.

[4] NACO, Annual Report 2013-14, p. 17
[5] *ibid., p. 19*
[6] HIV Sentinel Surveillance 2012-13- A Technical Brief, NACO

7. Promoting Correct and Consistent Usage of Condoms

Context and Challenges

When exploring why nearly 86% of HIV transmission was through unsafe sex, it was found that the availability of commercial condoms was restricted to urban India and that the private sector had a limited interest in rural areas due to high distribution costs. This, along with the absence of technical and professional management of condom promotion, was a barrier to HIV prevention activities.

To address these impediments, National AIDS Control Organisation (NACO) recognised the need to have a 'single national programme' with a 'targeted approach' to ensure availability of subsidised condoms to consumers in high prevalence districts. Under the National AIDS Control Programme (NACP) of NACO, promotion of the correct and consistent use of condoms was envisioned as a major component of the HIV prevention initiative.

NACP I (1994-1999) focused on ensuring the availability of condoms and promoting their usage. Non Governmental Organisations (NGOs) were engaged to publicise usage and distribute free condoms to High Risk Groups (HRGs). During

Box 1: Objectives of Condom Promotion

1. Increasing demand for condoms among HRGs and general populations by expanding social marketing to saturate coverage in high HIV prevalence and/or high fertility districts
2. Maximising access of free condoms with HRGs and increasing sales in rural areas thus making condoms available through non-traditional outlets

NACP II (1999-2007), the focus shifted to behaviour change communication, with the intention of boosting condom usage among HRGs. This was the beginning of the Condom Social Marketing Programme (CSMP). From 2007, under NACP III, a significant strategy that increased consistent condom use was starting a Technical Support Group (TSG) for Condom Promotion. The role of the TSG was to facilitate the design, implementation, monitoring and evaluation of the condom promotion programme (**Box 1** lists its main objectives).[1]

The Approach: Response and Solutions

Consistent condom use has been one of the most critical aspects of the HIV prevention strategy. Targeted at both

family planning and HIV/Sexually Transmitted Infection (STI) prevention, NACO's Condom Promotion strategy focuses on two aspects: **ensuring availability** and **creating demand** for condoms.[2] Availability is addressed through three components:

1. *Free Condoms:* Procured by the Ministry of Health and Family Welfare (MoHFW), these are distributed by NACO to HRGs through Targeted Intervention (TIs).

2. *Socially Marketed Condoms* are distributed by NACO through its Social Marketing Organisations (SMOs). For greater impact, the CSMP focus is on high priority districts, TI sites, trucker halt points, migrant districts (source, transit and destination points) and large construction sites. Social marketing agency operations are closely linked to programme objectives and real time monitoring of implementation ensures timely intervention and corrective action.

3. *The Female Condom Programme* empowers a Female Sex Worker (FSW) to protect herself from HIV infection by using female condoms wherever negotiations with clients are difficult.

One factor that played a key role in the success of the programme was a carefully worked out strategy to generate demand for condoms. This included roping in SMOs, NGOs, government organisations, individuals as well as the mass media to spread the message of safe sex and the importance of condoms in HIV/STI prevention as well as family planning. Though the Government of India had a condom promotion strategy for contraception since the 1960s, the HIV/STI prevention component was added in the 1990s to increase the demand for condoms, streamline their distribution, open new channels for social marketing and ensure accountability.

Capacity building of the staff involved in condom promotion

[1] http://naco.gov.in/NACO/National_AIDS_Control_Program/Services_for_Prevention/Condom_Promotion/
[2] *ibid.*

activities was a major part of the programme. A 'Condom Promotion' training manual was designed for TI staff. The TSG and NACO partnered with State AIDS Control Societies (SACS) to impart training to TI staff. Regular monitoring of the TIs by the TSG team became a part of the programme.

Results

Due to these efforts there has been a phenomenal growth in the market. Total Condom Distribution has grown from 1.8 billion pieces in 2007-08 to over 2.7 billion pieces by March 2014.[3]

Annual off-take of condoms, socially marketed by both MoHFW and NACO, has shot up by 77% from 614 in 2007-08 to 831 million in 2013-14. In rural areas, the paid condom market has grown by 70% from 2007-08 to 2012-13, while the social marketing condom market grew by 42% (**Figure 1**).[4]

Accessibility of condoms at any location within walking distance has been reduced from 30 minutes to 19 minutes (15 minutes in urban and 21 minutes in rural).[5] **Figure 2** measures the impact of various components from 2006 to 2010.

Due to rigorous implementation, there was an overall increase in the awareness of the correlation between condom usage and HIV prevention, the benefits of consistent use of condoms, and knowledge about its accessibility. Condom distribution is currently spread over 22,091 hot spots covered by NGOs under TIs.[6]

Figure 1: Condom Market Trend from 2007-08 to 2013-14

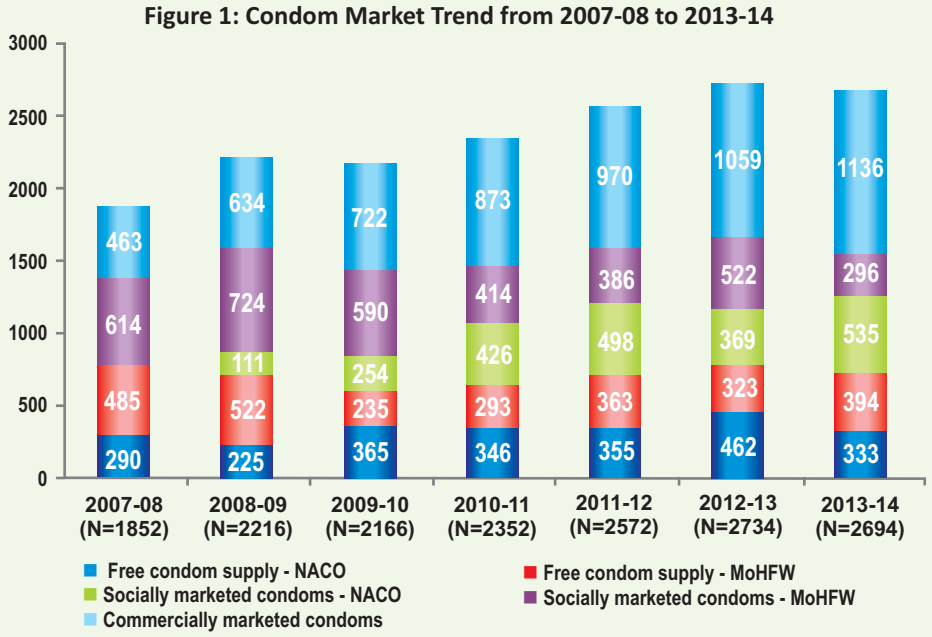
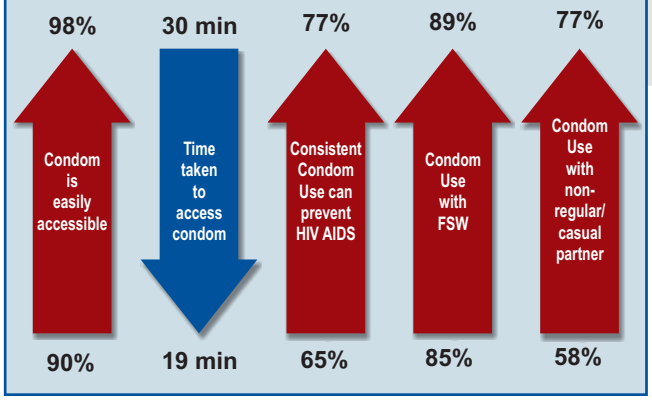


Figure 2: Impact of NACO's Condom Promotion Programme



Experiences and Lessons Learnt

For sustainability, there needs to be a steady move away from free distribution towards paid condom usage. Towards this end NACO introduced subsidised condoms with extra features to encourage customers who could afford to pay, to move from free condoms to paid condoms. This helped in ensuring that the free condom programme continued to cater to needy clients who could not afford paid condoms. Simultaneously TI personnel were made aware of the importance of preventing wastage of free condoms during distribution.

On a day-to-day basis, the gap between supply and demand must be understood and bridged. A consistent and uniform reporting mechanism needs to be developed for all TIs to monitor the distribution and use of condoms, especially for those undertaking social marketing of condoms.

[3] NIELSEN and Ministry of Health & Family Welfare
[4] http://naco.gov.in/NACO/National_AIDS_Control_Program/Services_for_Prevention/Condom_Promotion/
[5] Condom Promotion Impact Survey 2010
[6] NACO, 2014. Condom Promotion Communication Volume 6, August 2014.

8. Transition of Targeted Intervention Programmes from Donors to Government

Context and Challenges

Targeted Interventions (TIs) with High Risk Groups (HRGs) have been operational from 1999, whereas funders like the Bill and Melinda Gates Foundation launched large-scale programmes only after 2003. The Indian government's adoption of the 'Three Ones Principles' requiring only one agency, one programme and one framework, coupled with the possibility of donor withdrawal after fixed project time frames led to the need for continuity of services for HRGs. The National AIDS Control Programme (NACP) took the responsibility to ensure continuity both in terms of scale and quality of programmes through transitioning them from donors to the government.

The challenge lay in bringing stand alone, vertical health delivery systems supported by different donors under the National AIDS Control Organisation (NACO) umbrella. In simple terms, a **reverse strategy** was required to ensure that all programmes could be incorporated within NACO's mandate. Variations in implementation strategies, service provision, staffing patterns and costing in diverse states, contexts, communities and geographies had to be taken into account and suitably modified to fit in with NACO's standardised guidelines for TIs. This required: a) Extensive dialogue between donors and NACO, b) Detailed planning with state lead partners and State AIDS Control Societies (SACS), and c) Involvement of implementing Non Governmental Organisations (NGOs) and community based organisations (CBOs) and key population groups, so that TIs could be aligned to NACP III guidelines in a smooth and efficient manner. Transition of TIs also had to incorporate the successful strategies and innovations that donor programmes had demonstrated. The consensus was on ensuring the best utilisation of resources and uniform reporting while minimising duplication in coverage and reporting.

"Transition is not mere handholding of financial support or management of programmes implemented by NGOs or CBOs. It is the continuation of ensuring availability of services to the most at risk communities".

The Approach: Response and Solutions

Strategic planning envisaged the transition process as three phases over a four year period between 2009 and 2012, as summarised in **Figure 1**. The process encompassed skills development, system strengthening and the transfer of knowledge, strategies and technology between stakeholders. This process was planned meticulously several years in advance.

Figure 1: The Planning Process for Transition of Programmes for Sustained HIV Response

The transition from donor to SACS[1] followed a methodical process (see **Box 1**). Non-negotiable components from the government's view point were that TIs follow the NACP III budget guidelines, mode of health service delivery and peer led model for outreach. This meant that TIs which earlier spent up to USD 40 per key population member (unit cost) would get only USD 28 after transition.[2] This budget cut led to re-structuring of staff and a renewed emphasis on HIV prevention services.

Box 1: Systematic Process for Transition of TIs from Donor to SACS

- Consensus on common guidelines developed for transition
- Building capacity and preparedness for transition among NGO/CBO team members
- Formation of committee for transition and coordination
- Assessment of NGOs/CBOs by using standardised assessment formats and debriefing to the NGO/CBO
- Follow-up technical support and handholding through joint visits by the donor agency, state lead partner and Technical Support Unit for smooth transition to SACS

By 2007, donors identified three levels where transition processes would need to be instituted: a) National level -

[1] USAID, 2012.Final Report on AIDS Prevention and Control (APAC) Evaluation
[2] Avahan, 2009. Process, Outcomes, and Lessons Learned from First Handover of Avahan Interventions in Karnataka State (KHPT) http://www.khpt.org/reports%20pdf/KHPT_Year%201%20Transition_sankalp-1.pdf

Box 2: NACO's Key Criteria for Transition

a) Ensure both the programme and budget were aligned to NACO norms. From the programme point of view, there was a shift from a more community based approach to a targeted health service delivery mode. From the budget point of view, there was a drop in the unit cost by about INR 500 (USD 8) per HRG member

b) Monitor quality performances against NACO indicators – more than what was being monitored in the donor programmes. New monitoring formats were introduced at all levels for timely and quality data reporting

c) Review the implementing organisation's management and financial capacities

d) Identify TI staff capacities in terms of technical skills and specific areas for post transition support

NACO; b) State level – SACS, lead partner NGOs at state level and implementing NGOs at district level; and c) Community level with established CBOs.[3] Donor TIs, through their State Lead Partners (SLPs), planned for transition to fit criteria laid down by NACO as summarised in **Box 2**. The SLPs held extensive workshops with their NGO and CBO partners to align the programmes to fit NACO norms. A series of stakeholder meetings along with the Department of Health, other government agencies and community groups helped clarify roles and ensure buy-in.

Clear strategies were implemented to address challenges faced during the transition process:

a) **Fixed staffing patterns**: In donor supported TIs, most implementing partners had some flexibility in deciding the number of staff and their roles. NACO guidelines fixed the numbers and designations of staff in consultations with donor agencies.

b) **TI coverage limited to 1,000 members:** Prior to transition, most TI sizes varied according to the capacity of the implementing NGO. In some states, each district was managed by one NGO partner, regardless of the numbers of HRGs.

c) **Health service delivery**: NACP III guidelines mandated that health services in a TI focussed on STI treatment and HIV screening with clear targets. The mandate for delivering general health services remained with the National Health Mission.

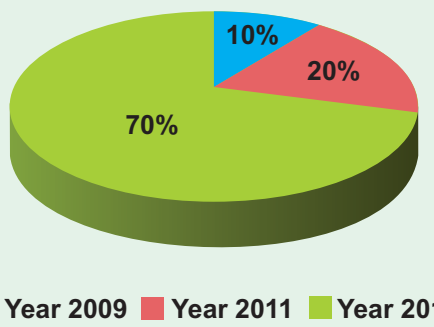
d) **Aligning to NACO's reporting formats**: Within a specified time frame, all implementing partners followed NACO reporting formats when they transitioned in order to receive funding support from SACS.

While considerable effort and resources went into the pre-transition and transition phases, equal emphasis was placed on the post-transition handholding and support given to implementing partners at all levels.

Results

The goal of ensuring a 'sustained HIV response through an effective transition' was successfully achieved with all donor TIs transitioned by 2012 with handholding support continuing until 2014.[4] As demonstrated by **Figure 2,** 100% of TIs in India transitioned in just four years. Currently 1,825 TIs are being implemented as per NACP guidelines covering 80% of HRGs in 2013, up from 778 TIs and 30% coverage in 2007.[5] The meticulous process and effectiveness of this smooth transition was demonstrated by the fact that none of the existing TIs collapsed or closed down.

Figure 2: Proportion of TIs Transitioned



Today, NACO can claim with pride that there continues to be a significant decline in HIV prevalence in states where donor-supported TIs transitioned to NACO. Other positive outcomes were that NACP could be implemented by a large number of well-established, trained NGOs and CBOs who continued the TI programme. This avoided having to identify new partners and ensured a seamless shift with no gap in services delivered to HRGs at any point in time.

Experiences and Lessons Learnt

Experiential learning which emerged from painstaking efforts to facilitate this transition through extensive dialogue, collaboration and coordination between key stakeholders at all levels is unmatched including:

a) Detailed meticulous planning and communication at all levels was a pre-requisite for the smooth transition of initiatives from donors to government.

b) Cross-learning and sharing of innovations and best practices was incorporated by NACP IV.

c) A robust technical support team was essential for transition and post-transition phases.

d) Community participation using a 'holistic human approach' rather than a 'target' approach ensured ownership of key populations over the TI programme.

[3] Sara Bennett et al., 2011. Global Health Action
[4] *ibid.*
[5] NACP IV Presentation, February 2015

9. Drop-in Centres and Safe Space Arrangements in HIV Prevention

Context and Challenges

Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TG) and Injecting Drug Users (IDU) are among the most marginalised populations in India. These High Risk Groups (HRGs) have remained invisible despite the availability of HIV prevention services. The lack of supportive spaces made it difficult to identify and reach out to HRGs who were reluctant to accept HIV risk reduction services because they feared family and public disclosure, oppression by police, social stigma and also possible penalties under prevailing laws. When outreach staff attempted to contact HRG members at sites and hot spots, they soon realised that although individuals and small groups could be met, it was impossible to achieve coverage targets unless members felt safe meeting in larger groups and could actively participate in HIV prevention programmes.

The biggest challenge faced by Targeted Interventions (TI) was bringing groups with diverse needs and expectations together, to achieve the shared goal of HIV prevention and epidemic control. Initially, FSW refused to share a platform with MSM and TG. IDU felt their needs were completely different and their priority was harm reduction services like safe needles, syringes and Opioid Substitution Therapy (OST). Even within the same risk group, members of different typologies (for example, street-based, brothel-based, home-based and lodge-based FSW) exhibited differing group dynamics which needed to be addressed.

Box 1: Criteria for DIC as a Safe Space

- HRG Members should feel at ease and have no fear of being intimidated, hurt or penalised for their behaviour
- Should serve as a place to meet, share hopes and ideas and be heard
- Should increase access to prevention services like counselling, condoms, referrals and linkage services
- Should serve as a space to build group strength for taking ownership of the programme

In India, (**Box 1 and Figure 1**) Drop-in Centres (DICs), also known as 'Safe spaces', have been a key element of interventions with HRGs since 2002. Under NACP III, most services at the TI level are provided through two broad strategies; 1) the outreach strategy, which involves reaching out to community members of HRGs and providing services at locales where members congregate, and 2) provision of services through the DIC which is a static service point.

Figure 1: Activities of DICs

The Approach: Response and Solutions

Under NACP III, all TIs for HRGs have instituted DICs as multi-functional hubs playing a pivotal role in both service provision for HIV prevention and community empowerment for programme sustainability. Establishing DICs was done through a well planned process that included: a) mapping HRGs and hot spots; b) mapping services and referrals; c) considering budget and feasibility; d) consulting communities through group discussions; e) considering the locality and attitude of residents. The rationale and process of establishing functionally effective DICs to cater to the needs of the communities, while furthering the cause of HIV prevention, is outlined below.

Location, Infrastructure, Timings and Ground Rules: As safe spaces are entry points in service delivery, their location is critical. The three 'A's (Availability of services, Accessibility in terms of distance and timings and Affordability in terms of cost of travel to reach the DIC) are important factors. Most DICs are located close to hot spots and cruising sites where FSW, MSM-TG and IDU congregate. The choice of a centre's location and its signboards are also dictated by the preference of the community as to whether it should stand out or be relatively anonymous. As basic infrastructure, DICs must have safe drinking water, a clean toilet, adequate ventilation, sufficient room to conduct activities and provide services like private counselling. When a DIC has a static clinic, it is housed in a separate room appropriately furnished for the doctor to examine patients and protect their privacy. Convenient DIC timings are an extremely important factor to enable HRGs to access services. While FSW usually prefer coming in late in the morning and leaving early evening, MSM like to use the space late in the evening. DICs are designed as informal spaces but do have a set of rules. Members and visitors must treat each other with respect as

Box 2: Information Displayed in DICs

- Brief information about the organisation implementing the TI
- Organogram of the organisation
- Names and contact details of staff
- Service area and hot spots
- Timing/ hours
- Helpline numbers and Emergency helpline
- Rules of Conduct
- Details of grievance redressal mechanism and how to access it

the space is equally for their peers and other community groups to share. **Box 2** details prominently displayed information in a DIC.

DIC Services for HIV Prevention: The DIC serves as a stock and service point for holding essential supplies such as male and female condoms, lubricants, drugs (for OST, other infections), sterilised needles and syringes (for IDU to exchange), equipment and medical supplies necessary for other treatment services in clinic programmes, along with cleaning materials and waste disposal containers. A non-stigmatising clinic within the DIC provides supportive counselling, referral health care facilities and treatment services. Staff and peer workers also use DICs to plan and improve outreach.

Safe Space Activities: Apart from being a meeting place for HRGs to share, care and support each other, DICs are ideal

Box 3: Creativity in DIC Activities

The DIC was designed in response to the community's need to rest and relax. It served as a space for behavioural interventions and its clinic provided a host of HIV risk reduction services. In some DICs, members were also led into 'Prayer time' to pray for their peers in distress. 'Sharing time' was meant for discussing issues faced by individual members with families and society. The DIC housed a cloth bank where community members donated clothes and a food bank wherein members brought a fistful of rice which was set aside on a daily basis. The clothes and rice are used for peers during times of crises. The DIC was supervised and led by a committee of community members.

spaces for detailed discussions with communities, conducting events and edutainment for greater participation. Training workshops, skill building and income generation programmes are held in response to demand. They serve as spaces for advocating with government officials, law enforcement authorities, local leaders and residents towards creating an enabling environment for marginalised communities. HRGs come together there to celebrate national days, religious and community festivals. Other popular DIC activities include capacity building for savings and credit through self-help groups. Besides serving as a space for rest and recreation, it provides a platform for committees to provide feedback on the quality of TI services. Flexibility and creative use of DICs benefit HRGs (see **Box 3**).

Results

These safe spaces for HIV prevention activities and services also enhance self-esteem and respect for vulnerable

Box 4: Community Voices on DIC

'This centre is a home for us. We look forward to coming here, to meet and share problems, even celebrate festivals without any false façade. The drop-in centre encourages us to use contraceptives, which are provided free of cost, and undergo medical examination regularly'.
- FSW

'Even my own parents had disowned me. To come to a safe space, be treated with respect and not be blamed makes me feel like taking care of myself and doing good work for my community'. **- TG**

communities (**Box 4**). Identification, training and mentoring is made easy and peer workers and volunteers act as positive re-enforcers for behaviour change in the community. DIC activities have helped strengthen the agency of marginalised groups. As an indirect impact of community mobilisation and empowerment through collectivisation and

Box 5: Community Involvement Shows the Way for IDU

The involvement of former IDU in some states led to income-generating activities, such as producing handicrafts and decorative items in the DIC. For instance, a community-run barbershop has been used to incentivise access to clinical services. IDU receive a free haircut if they visit the STI clinic! The IDU community is not only motivating peers for HIV risk reduction but is also increasingly involved in strategising productive work for community members.

strengthening leadership capacities, CBOs of HRGs are key contributors to successful HIV prevention efforts (**Box 5**). One can infer from these efforts that society and government has recognised the need to not only decriminalise sexual orientation and practices but are also attempting to put systems in place for reducing vulnerability of these populations.

Experiences and Lessons Learnt

Enabling the group to decide which strategies are appropriate and how they should be implemented needs time and patience. In establishing and running DICs, awareness of the laws and legal environment is important. The DIC should have basic infrastructure, regular timings, and consistently provide services. Adherence to 'Standards of Conduct' is crucial and coming down on unacceptable behaviour through community consensus from the outset would earn respect in the neighbourhood and prevent untoward action against marginalised HRGs.

10. Innovative STI Prevention and Control Strategies for High Risk Groups

Context and Challenges

Early diagnosis and treatment of Sexually Transmitted Infection (STI) and Reproductive Tract Infection (RTI), greatly reduces HIV transmission while also preventing infertility, ectopic pregnancies and mother to child transmission. In 2002[1], the prevalence of STIs and RTIs among sexually active adults in India, was 5% to 6%, resulting in an annual incidence of 30 million STI/RTI episodes. Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TG), Injecting Drug Users (IDU) and bridge populations (truckers and migrants) are considered High Risk Groups (HRGs), with reference to their risk for acquiring or transmitting HIV or STI. The enhanced risk is behaviour related namely having multiple sexual partners, inconsistent condom use and injecting drugs. Past studies have shown a startling STI prevalence rate, ranging between 22% to 31% among FSW[2] and 6% to 17% among MSM.[3] Obstacles like stigma and discrimination in health care settings result in poor health-seeking behaviour among HRGs which in turn acts as a deterrent for accessing available STI/RTI services.

Recognising the need to customise STI services to the needs of HRGs, the National AIDS Control Organisation (NACO) introduced a flexi-model approach for STI and RTI management as a key HIV prevention strategy in its National AIDS Control Programme (NACP).

The Approach: Response and Solutions

From 2007, NACP III offered standardised sexual and reproductive health services to HRGs through a **flexi-model approach**.[4] **Box 1** shows the different models of STI/RTI services provided by Targeted Interventions (TIs) to ensure freedom of choice and ease of access to quality care.

Syndromic STI/RTI Color Coded Kits

NACO engaged various stakeholders through a consultative process, to design a standardised curriculum. Capacity building and sensitisation of service providers (doctors, nurses, counsellors and laboratory technicians), was prioritised. A cadre of national, state and regional resource faculties used a 'cascade model' to train doctors on **Enhanced Syndromic Case Management** (ESCM) of STI/RTI using specially developed colour coded, pre-packaged drug kits, which became the cornerstone of STI/RTI management. Immediate treatment provided on the first visit, with minimal or no laboratory tests, achieves high cure rates.

Knowing that HRGs were reluctant to seek help for STIs, outreach and peer workers in TIs motivated them to undergo a Regular Medical Check-up (RMC) in community friendly clinics. This highly successful approach meant HRGs were happy to speak with counsellors, be examined by sensitised doctors and get free treatment for their STI/RTI problems. They

Box 1: Models of STI/RTI Service Delivery in TI Programmes

1. **Static or Fixed Clinics:** This is a project-linked clinic located at a drop-in centre (DIC) or around 'hotspots' where there is a large congregation of HRGs
2. **Preferred Private Providers:** Private healthcare providers are doctors located in and around the intervention areas and are chosen by the community
3. **Referral to Government Health Facilities:** HRGs are also referred to government Designated STI/RTI Clinics (DSRC) named 'Suraksha' (meaning protection) that are set up in every district
4. **Health Camps**: Migrant populations are provided STI/RTI services through periodic health camps in out-migration districts
5. Combination of above models are used to provide greater choice and enhance access to STI/RTI services

[1] NACP III Report on Mid-Term Review of Sexually Transmitted Infection Services, December 2009
[2] Desai et al., 2003; Pal et al., 2004; Wayal et al., 2011
[3] Brahmam et al., 2008; Gupta et al., 2006; Kumta et al., 2010; Setia et al., 2006; Solomon et al., 2010
[4] NACO, 2011. Operational Guidelines For Programme Managers and Service Providers for Strengthening STI/RTI Services; May 2011

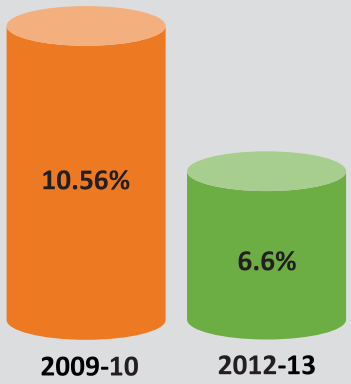
were also open to discussing other sexual health issues and symptoms with peer counsellors and outreach workers. **Box 2** details the package of clinic services from regular medical checks to STI treatment to referrals. Linkages between outreach, DIC activities, clinics and referral services increase RMC significantly. Every individual is tracked for uptake of services through the Management Information System (MIS) in the TI.

Results

Under the NACP, 1,744 TIs provide standardised STI/RTI services to HRGs.[5] About 6.33 million cases were managed at DSRC public health delivery points in 2012-13, achieving over 90% of the national STI/RTI target.

Single window service delivery points allow increased access to tests for STIs and HIV. Consistently meeting targets since 2009 resulted in a significant decline of bacterial STIs, especially syphilis.[6] Of the total coverage of 980,118 HRGs in 2009-10, 103,464 STI/RTI episodes were treated (10.56%). In 2012-13, of a total coverage of 1,200,154 HRGs, 3,365,075 STI/RTI episodes were treated resulting in a reduced rate of 6.6% (see **Figure 1**).[7]

Figure 1: STI/RTI Episodes Treated as a Proportion of Total HRG Coverage



Close to 4,500 doctors in private practice are linked with the TI programme as preferred providers thereby contributing to future sustainability of STI/RTI service provision for HRGs. A preferred private provider selected by the community itself helps improve accessibility and ownership. The innovative colour coded drug kits along with the involvement of private practitioners on scale are globally recognised best practices.[8] Another innovation, Point of Care (PoC) syphilis screening has been implemented by partners in some states.

Experiences and Lessons Learnt

The NACO experience of successfully scaling up STI/RTI services for HRGs demonstrated that making clinics community friendly is a challenge that must be met. An appropriate mix of STI/RTI facilities delivering standardised services can provide choices which maximises use in a cost effective manner. Establishing a centralised STI capacity building group is important to ensure standardised and high quality implementation on scale.

Box 2: Package of STI Services in TIs

Regular Medical Check-up (RMC): Members of HRGs are identified through active outreach and referred every quarter for routine medical examinations like speculum or proctoscopy screening for asymptomatic STI. Counselling for reducing high risk behaviour and condom promotion are also part of the RMC

Symptomatic Treatment: Treatment for symptomatic STI patients is provided through Syndromic Case Management (SCM) with pre-packaged drug kits

Presumptive Treatment: It is well known that 50% of all STI are asymptomatic. HRGs attending the clinic for the first time or returning after a gap of six months are provided with presumptive treatment for STI, if they are asymptomatic

Bi-annual Syphilis and HIV Screening: Every six months, all HRG members are screened for syphilis and referred to Integrated Counselling and Testing Centres (ICTC) for HIV counselling and screening

Referral Services: Referrals are provided for TB screening and treatment, Anti-Retroviral Treatment, Prevention of Parent to Child Transmission, and to Reproductive and Child Health (RCH) services

Community Perspective on STI Services

I have been coming to the clinic for RMCs for the past 5 years. In the initial years, I had suffered from STI more than three times and was treated with drug kits. But now, I feel reassured that all is well.

- **FSW**

[5] http://naco.gov.in/upload/NACP%20-%20IV/Consultations%20II%20July-Aug%202011/STI%20TWG%20report%20final.pdf
[6] NACO Annual Report 2013-14
[7] A Gurung et al; Individual tracking among high risk groups for STI management in India: an analysis of 400000 high risk groups followed from 2004 to 2009
[8] NACO Annual Report 2013-14. p.36.

11. Use of Technology for Awareness Programmes

Context and Challenges

Misconceptions and myths on HIV, taboos on sex or condoms, inadequate information and the associated stigma of being seen at places associated with HIV act as barriers to right information on HIV. At the launch of the fourth phase of India's National AIDS Control Programme (NACP IV), priorities stressed were addressing stigma and discrimination, creating awareness and education about the disease and providing information on HIV/AIDS and Sexually Transmitted Infection (STI) services.[1] To scale up reach of HIV awareness programmes, uniform and clear information as well as greater efficiency is needed. This needed low-cost technologies such as social media and mobile technologies, online resources, information, and learning opportunities for anonymous dissemination of information on HIV and related issues. This would also include educating People Living with HIV (PLHIV) to cope with the disease, reducing stress, ensuring adherence to treatment and follow-up.

The Approach: Response And Solutions

Information Technology is used extensively to reach out to High Risk Groups (HRGs), Bridge Populations, as well as general populations with information on prevention and treatment. The type of target audience, their literacy levels, demography and typology, were all kept in mind while devising technological interventions to raise awareness and education. In addition to use of mass media, folk media, mid-media and print media, for technology-friendly populations, mobile phones, websites, e-learning and Facebook were used. As India is the second-largest mobile phone user with over 960 million users, telephone helplines and SMS services were used.

1097 National Helpline: National AIDS Control Organisation (NACO) launched a national toll free AIDS helpline on December 1, 2014. It is accessible through any landline or mobile phone from any part of the country. The helpline serves People Living with HIV (PLHIV) and High Risk Groups (HRG). This helpline provides an inter-active confidential counselling and information service offering support, guidance and referrals for callers. Significantly, the service is available in eight languages.[2] Round the clock call centres have been set up in three different locations: Jaipur for the northern region, Guwahati for the eastern region and Hyderabad for southern and western regions. The central data centre is based in Hyderabad.[3]

HEROESINWHITE: An online campaign "HEROESINWHITE" was implemented by NACO in association with the Indian Medical Association (IMA) to engage doctors on the issue of stigma and discrimination faced by PLHIV at healthcare settings and urge them to lead the change in providing equal care to all patients. The campaign was launched on Doctor's day July 1, 2014. During the campaign an exclusive website HEROESINWHITE.COM was created to anchor the campaign, a dedicated Facebook page was prepared and special messages through mailers were sent to more than 2.5 Lakh registered doctors. The campaign captured a good number of success stories from across the country.

Hello + and Saadhan Helpline: A public-private partnership model was put in place in the form of a helpline (Branded as Hello+ and Saadhan helpline), to provide information related to HIV prevention and treatment including referral services. While Saadhan Helpline provided prevention services to target groups in the state of Maharashtra, Hello+ covered the Southern part of India with information on prevention and treatment services in Tamil, Telugu, Hindi and English languages. Demand was generated to use these helplines through various on ground communication activities carried out by key stakeholders including SACSs.

[1] NACO Annual Report 2013-14. p.8
[2] http://www.keralatelecom.info/2014/11/bsnl-allocates-short-code-1097-as-AIDS-HIV-helpline.html
[3] NACO Newsletter, October 2014-March 2015

SMS Facility: The SMS facility was started on March 2010 and ran successfully for one year. The information pertaining to various services provided by Government facilities, Non Governmental Organisations, Community Based Organisations and Positive networks of PLHIV were sent via SMS. If a caller was interested in receiving information, she/he could voluntarily provide their personal contact number.

Warmline Expert Physician Access Number (EPAN): EPAN provides on-demand technical advice to HIV clinicians treating PLHIV which helps improve services. This facilitated the establishment of a national network of HIV clinicians, who work together to address challenging issues through case discussions, knowledge sharing and lectures. The National Distance Learning Seminar (NDLS) Series has also been set up to provide up-to-date and evidence-based information on HIV/AIDS care and management to health care professionals. The Regional Distance Learning Seminar (RDLS) conducts training in the regional language for local participants.

Distance Learning through Centres of Excellence (CoE): CoE hold training programmes for health care providers as per NACO prescribed curriculum through designated faculty, who mentor them regularly. They also use tele- medicine, e-discussions, distance learning for sharing good practices and Continuing Medical Education.

Inventory Management System: The programme managed by NACO is an inventory driven programme that requires robust supply chain management systems for efficient utilisation of resources. To monitor and record distribution of HIV drugs, NACO with support from Clinton Health Access Initiative, has developed and implemented an Inventory Management System for recording and improving access to drugs for patients across India. This system would be used by all suppliers, SACS and ART centres to record and monitor distribution of drugs using bar-coding of commodities and Aadhar Card based UID. The system would provide real time reports and support data-driven decision-making across supply chains. The system has been implemented at the SACS level across the nation and is in the process of being scaled up to all suppliers and ART centres.

Online Repository: NACO's India HIV/AIDS Resource Centre, (http://indiahivinfo.naco.gov.in) is a digital resource centre which serves as an e-resource portal for knowledge management of print and non-print materials on HIV/AIDS developed by NACO and other agencies. These electronic resources can be accessed by organisations and individuals globally, supporting teaching, learning and research while allowing ease and speed of locating information.

Box 1: Independent evaluation of Hello +

Of the total callers, it was found that:

- 93% felt that confidentiality was maintained
- 89% said that the counsellors had understood their issue
- 87% said that they felt comfortable talking to counsellors
- 91% said that the counsellors used appropriate words
- 87% stated that the counsellors were polite to them
- 97% stated that all their queries were addressed

Results

The findings of the studies on technological applications found that they could significantly promote HIV awareness. Key achievements of some of the technologies used in HIV prevention are presented below:

The toll-free national helpline '1097', was an instant success with over 3,800 calls[4] coming in from all over the country. The information sought related to HIV/AIDS, on modes of transmission, prevention, cost of testing and treatment, location of facilities etc. People preferred the helpline as it offered confidentiality where the caller would only be heard and not seen or identified.

Hello+ was found to be (see **Box 1**) highly effective as a helpline[5] and received a daily call load of about 1,000 calls on an average with most callers being in the age group of 21 to 25 years. Though calls were received from PLHIV, majority came from the general population.

Experiences And Lessons Learnt

Maintaining anonymity and confidentiality was one of the key factors in determining the success of the new technologies and services. Capacity building on managing these technologies and catering to target populations was a pre-requisite for success. The campaigns and interventions were devised keeping in mind the need, demography, accessibility and literacy levels of the target audience. Efforts were made to build capacities of service providers to implement campaigns tailored to these communities.

[4] http://www.dnaindia.com/mumbai/report-centre-launches-helpline-on-hivaids-with-a-human-touch-2040138
[5] APAC-VHS, 2012

12. Enhancing Syphilis Screening Coverage of Different Sub-populations in HIV Prevention Programmes

Context and Challenges

Like HIV, Syphilis is a Sexually Transmitted Infection (STI) which affects similar patient and population groups around the world. It is caused by *Treponema pallidum* and simple to cure, but if left untreated it can cause serious complications. Early detection and treatment prevents adverse medical consequences, transmission to sexual partners and from mother to child, thereby reducing the risk of HIV acquisition and transmission.

Studies over the last ten years in India have shown high syphilis prevalence among Female Sex Workers (FSW), Men who have Sex with Men (MSM), and Injecting Drug Users (IDU), ranging from 1.7% to 39.7%, 3.0% to 17.0% and 0.9% to 19.5% respectively.[1] Of the 2.3 million attendees screened for syphilis in designated STI and Reproductive Tract Infection (RTI) clinics under National AIDS Control Organisation, 14,507 (0.62%) were found to be sero-reactive.[2] Of an estimated 2.9 million pregnancies in India during 2010-11, the burden of syphilis among pregnant women was 0.1 million.[3]

Laboratory diagnosis of syphilis traditionally involves screening using Rapid Plasma Reagin (RPR) or a Venereal Diseases Research Laboratory (VDRL) test followed by a quantitative non-treponemal test and/or specific treponemal confirmatory tests (see **Box 1**). The challenge lies in providing syphilis screening services across a range of health facilities accessed by different sub-populations, particularly pregnant women, High Risk Groups (HRGs), bridge populations and the general population.

Box 1: Syphilis Diagnosis

- Syphilis is diagnosed clinically by the presence of ulcer(s), non-itchy generalised rashes and by laboratory tests which consist of non-specific, non-treponemal and treponemal specific tests
- First line screening is usually performed with non-treponemal tests such as RPR or VDRL. Due to the possibility of false-positive results, confirmation for any qualitatively positive non-treponemal test result should be followed by a quantitative non-treponemal test and/or specific treponemal tests. Such tests include fluorescent treponemal antibody-absorption, *T pallidum* hemagglutination and *T pallidum* particle agglutination

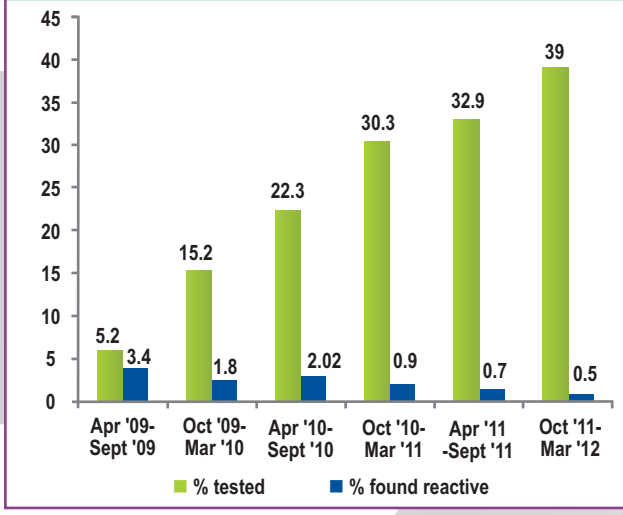
The Approach: Response and Solutions

Under National AIDS Control Programme (NACP) III (2007-2012), the national STI/RTI programme makes provision for accessible, good quality services to HRGs, bridge and general populations. Convergence links the experience and technical capacity of HIV prevention programmes of NACP with the infrastructure, human resources and wide community reach of the National Health Mission to ensure standardised STI/RTI care. This is particularly significant when providing quality testing, treatment and care to pregnant women, their partners and new born infants under the Maternal and Child Health (MCH) programme. Various modalities of STI/RTI services, including syphilis screening and treatment linkages for communities include:

Designated STI/RTI Clinics (DSRC): Located at district hospitals, medical colleges and select sub-divisional hospitals, DSRC '*Suraksha*' (meaning protection) clinics are primarily meant to provide STI/RTI services by trained physicians through enhanced syndromic management with minimal laboratory services. Syphilis screening is provided to HRGs as well as general populations. Quantitative testing is done to confirm the syphilis infection. Clients who test positive for syphilis are provided free treatment and referred for HIV testing. The DSRC has two service outlets, one for both sexes and the other for females providing cross referral linkages with Integrated Counselling and Testing Centres (ICTC), Targeted Interventions (TIs), Family Planning clinics, Adolescent Reproductive and Sexual Health clinics, general laboratories, Anti-Retroviral Therapy (ART) and Care and Support Centres. This ensures comprehensive coverage and better utilisation of DSRC services.

Syphilis Screening in Coordination with TIs: As part of their STI package of services, syphilis screening was introduced for HRGs in TI clinics run by Non Governmental Organisation partners every six months (see **Figure 1**). Outreach teams in TIs motivate communities to access STI and ICTC services regularly for syphilis and HIV screening respectively.

Figure 1: Biannual Syphilis Testing and Positivity from April 2009 to March 2012 under NACP III



***Khushi* Clinics for Bridge Populations of Truckers:** Highly mobile long-distance truckers need access to medical facilities where they travel. '*Khushi*' (meaning happiness) clinics have been established at all major trucker halt points in nine Indian states. Each point has an annual footfall of 20,000-30,000 truckers who stop to rest and repair their vehicles. *Khushi* clinics do not have their own laboratory services but use referral systems and established links with government laboratories for syphilis testing through RPR screening.

[1] Mugundu R. Parthasarathy et al. 2013.
[2] NACO Annual Report 2013-14.
[3] National Guidelines on Prevention, Management and Control of Reproductive Tract Infections and Sexually Transmitted Infections. July 2014

Truckers who test positive for syphilis are treated with drug kits under enhanced syndromic case management for STIs.

The Master Health Check-up (MHC[4]) Programme: In this initiative, TI field staff motivate HRG members to visit the clinic where they are registered by a counsellor and given a 'Master Health Check-up' card. After counselling, the medical officer conducts a general medical check-up, examines for STIs, identifies syndromes, locates the site of lesions (vaginal or cervical) and takes smears from discharge cases for microscopy. Female clients are further screened for cervical cancer. **Box 2** provides the package of services offered.

Box 2: Master Health Check-up (MHC) Approach

Tamil Nadu mainstreamed STI/HIV-related services into the existing government health system. The comprehensive package of investigations included:

- ***STI related investigations:*** RPR & treponemal tests for syphilis; Rapid test for HIV; tests for Trichomonas vaginalis, Candidiasis and Bacterial vaginosis; PCR test for Gonorrhoea, Chlamydia and Syphilis and screening for cervical cancer
- ***General investigations*** such as blood groups, complete haemogram, blood sugar and urea, blood pressure, urine examination

The MHC initiative was a success with a total of 47,178 HRG members (53.37%) accessing the services between December 2009 and March 2011.

'Single Window/Single Prick' Approach at ICTC: India's National STI/RTI Prevention and Control Programme mandates a screening test to detect asymptomatic and latent syphilis among all pregnant women attending Ante Natal Clinics (ANCs).[5] The 'single window' approach is designed to draw a sample of blood through a single venipuncture for all tests including syphilis, HIV and Hepatitis B, as part of the routine ANC test package. This means that when a pregnant woman accesses an ICTC, blood drawn just once is sent for multiple laboratory tests and results are made available in the shortest possible time. Since 2010, HRGs and bridge populations are counselled in ICTCs for both HIV and syphilis screening through the 'single window /single prick' approach.

Rapid Point of Care (POC) Test: The POC tests are treponemal tests used for screening hard to reach groups where even basic laboratory facilities are unavailable. The POC Immuno-Chromatographic Strip Test (ICST) was introduced in 2007 alongside the RPR test in TIs under the *Avahan*[6] initiative. A valuable syphilis screening tool, ICTC offers same-day testing and treatment with distinct advantages (see **Box 3**). Through Interpersonal Communication (IPC), community peers and outreach workers motivate HRG members to undergo biannual screening for HIV and Syphilis. Blood samples are easily collected and tested at Drop-in Centres and other sites conveniently accessed by the community. HRG members who test positive and whose history and clinical records indicate little or no past treatment for syphilis are treated with colour coded drug kits on the same visit.

Box 3: Advantages of POC ICST

- A simple finger-prick provides blood for the test and community acceptance of the test is high
- Syphilis testing is done in the clinic itself
- Test results are available in less than 15 minutes
- Immediate treatment with drug kits to ICST positive clients
- Any trained health worker can do the test
- No special equipment or electricity is needed
- The kits costing USD 0.39 proved to be cost effective
- Ease of access is greatly increased through project clinics, preferred provider clinics, outreach sites and mobile clinics

Results

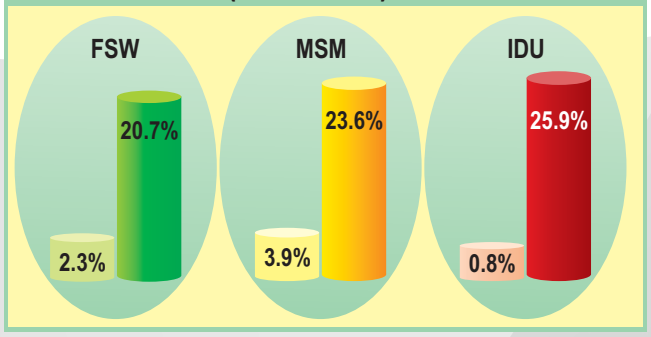
About 2.3 million pregnant women attending ANCs were screened for syphilis in 2013-14 and those who tested positive were provided treatment to prevent congenital syphilis in new born babies. The

Box 4: Prevention of Congenital Syphilis

A strategy 'Towards Elimination of Parent to Child Transmission of Syphilis by 2017' has been launched by the STI/RTI Control & Prevention Programme in collaboration with the Reproductive Maternal Newborn Child Health and Adolescent Programme (RMNCH+A) of the National Health Mission (NHM).

Elimination congenital syphilis (ECS) strategy facilitates prevention of Parent to Child Transmission of HIV and Syphilis. **Figure 2** shows

Figure 2: Proportion of HRGs Screened for Syphilis (2005 to 2009)



the tremendous improvement in syphilis screening rates and a decline in infection among HRG clinic attendees. From 2005 to 2009, the proportion of FSW, MSM and IDU screened for syphilis increased from 2.3% to 20.7%, 3.9% to 23.6% and 0.8% to 25.9% respectively.[7] Studies among FSW in South India from 2004 to 2011 show that HIV prevalence declined significantly from 19.6% to 10.8% and high-titre syphilis prevalence halved from 5.9% to 2.4%.[8]

Experiences and Lessons Learnt

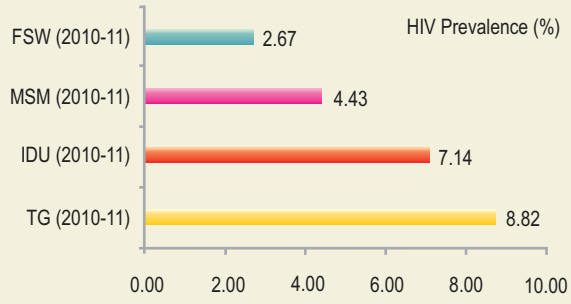
With systematic implementation of operationally-feasible strategies, syphilis screening can be effectively integrated into large-scale HIV prevention and MCH programmes. The point of care ICST with HRGs has the potential to be scaled up in other resource-constrained primary care settings such as ANCs. It enables screening pregnant women in labour rooms and provides on-site treatment. Replicating it can tackle the barriers of limited laboratory capacity for syphilis testing, logistical difficulties of blood storage and transport and overcome the need for trained laboratory personnel to draw blood and perform the test.

[4] MHC was jointly implemented by Tamil Nadu State AIDS Control Society (TANSACS), AIDS Prevention and Control Project (APAC) under Voluntary Health Services (VHS) and Tamil Nadu AIDS Initiative (TAI).
[5] DAC, 2013. National Guidelines for Prevention of Parent-to-Child Transmission of HIV, December 2013, p.21-22
[6] Avahan was the name given to targeted intervention projects supported by Bill and Melinda Gates Foundation in India.
[7] Mugundu R. Parthasarathy et al.2013
[8] Shajy Isac et al. 2015

13. Opioid Substitution Therapy as a Harm-Reduction Strategy

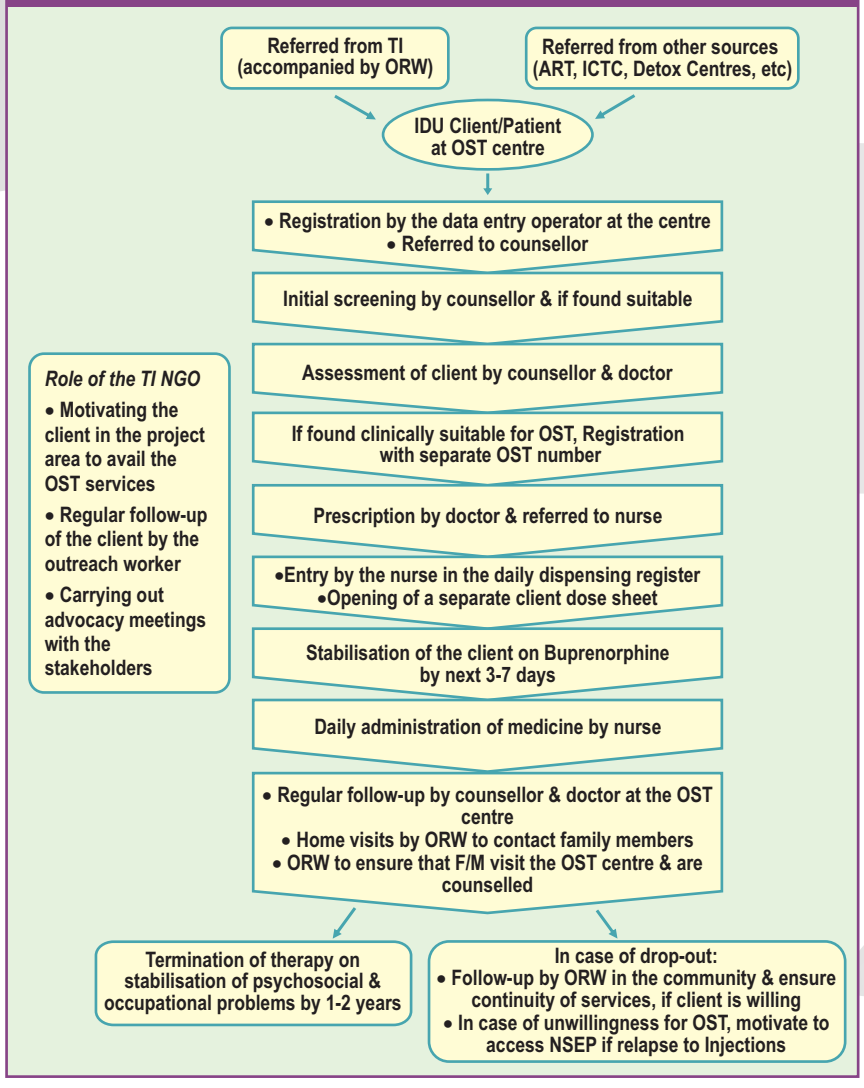
Context and Challenges

Figure 1: HIV Prevalence



The HIV epidemic in India remains largely concentrated among high risk groups comprising of the Female Sex Workers (FSW), Men who have Sex with Men (MSM) and Injecting Drug Users (IDU). **Figure 1** shows the HIV prevalence rate amongst HRGs as per the HIV Sentinel Surveillance Technical Report, 2010-11, NACO. Considerable decline has been recorded in HIV prevalence among IDUs in a number of states especially those that have been traditionally high in terms of IDU burden and high HIV prevalence. For example, from 2003 to 2010-11, Manipur recorded a decline from 24.4 to 12.8% while Nagaland showed a decline from 8.43% to 2.21%. This was possible due to the intensive efforts undertaken under the National AIDS Control Programmes (NACP) by the National AIDS Control Organisation (NACO), Ministry of Health & Family Welfare (MoHFW), Government of India in partnerships with community-based groups, civil societies, bilateral agencies, other Government departments and ministries, and so on. (see **Figure 1**).

Figure 2: Patient Flow Chart



The Approach: Response and Solutions

NACO adopted harm reduction as a policy in 2002 under NACP II using a peer led approach where services are made available at the 'doorstep' of IDU. Services under this policy include needle syringe exchange programmes, condom promotion, targeted information, education and communication, HIV counselling and testing, early diagnosis and treatment of Sexually Transmitted Infection (STI), abscess prevention and management, and linkages with Anti-Retroviral Treatment (ART) and Tuberculosis treatment.

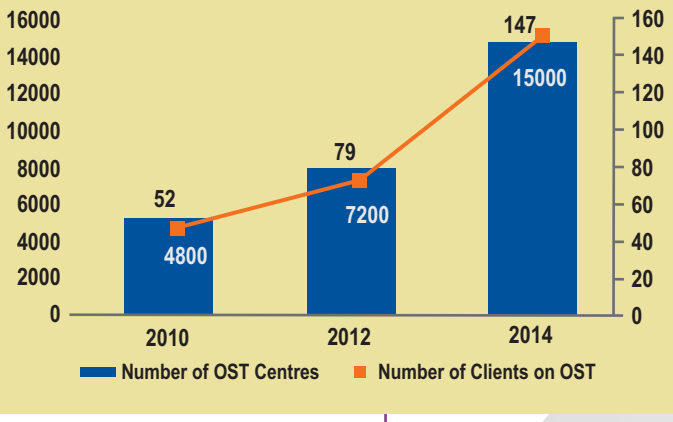
Under NACP III (2007-2012), Opioid Substitution Therapy (OST) was included as part of the Harm Reduction Package. OST involves substitution of illicit, unsafe opioid drugs which may be taken through injections, with a legal medicine which has similar properties as that of the opioid but taken through a safer route. The medicine is prescribed by a doctor and administered under the supervision of trained health care staff. As a replacement, OST effectively minimises craving and withdrawal symptoms thereby enabling IDU to stop or reduce injecting drugs, leading to decreased risk of transmission of HIV and other blood borne diseases. Under NACP III, OST was scaled up in community (delivered through non–governmental organisations) as well as public health settings (government health care facilities) to increase coverage (see **Figure 2**).

Peer Educators (PE) and Outreach Workers (ORW), who are either recovering drug users or under OST themselves, play an important role in TI

implementation across the country. Through a peer-led approach, they identify IDU in their own communities who need treatment, help others stay away from drugs, take care of other health needs and improve their quality of life.

A national plan for expansion of OST services was developed based on evidence from research, programme experience and epidemiological data about IDU populations. Specific **training** modules, guidelines and Standard Operating Procedures were developed on OST to standardise the services offered. As part of **quality assurance**, OST experts and mentors visit OST centres twice a year to interact with and guide staff and to assess quality of services. They report their observations and findings to NACO and State AIDS Control Societies as well as provide inputs and recommendations on specific areas of OST implementation. A system of **accreditation** was initiated every two years to assess infrastructure, staff, OST service delivery processes and programme performance. The National Accreditation Board for Hospitals & Health Care Providers, an independent agency, uses a standardised tool and draws from a pool of OST accreditors developed specifically for this purpose.

Figure 3: Coverage of clients in OST centres (2008 -2014)



Results

One of NACO's key strengths is its evidence-based approach. Size estimations and epidemiological research to support the design of community-friendly intervention strategies that reach IDU have been the centre of the national response. Increased acceptance of OST as a harm reduction strategy has contributed to scaling up the programme reflected in coverage more than tripling in four years (see **Figure 3**).

Major achievements under NACP III in implementation and scale up of OST centres include:

- Planning and executing a rapid scale up through increase in OST centres (52 to 147 from 2010 to 2014) covering more than 15,000 IDU in 100 districts across 29 State/District AIDS Control Societies.[1]
- Community-driven prevention programmes, inclusive of socio-culturally appropriate interventions for IDU and their sexual partners.
- Use of evidence and implementation experience in designing appropriate models for service delivery according to the local context and needs.
- Leveraging existing facilities and resources in the general health system to deliver services to IDU and their partners.

Experiences and Lessons Learnt

OST accreditation ensured minimum standards of care at the National AIDS Control Organisation supported OST centres. Standard protocols under quality assurance enabled regular on-site mentoring and capacity building of staff. OST has helped integrate IDU into the mainstream.

OST is an established strategy to prevent HIV among IDU, improve compliance to treatment and follow up, increase adherence to ART and improvement in overall functioning and quality of life amongst IDU. Therefore, consolidating the gains made till now, NACP IV aims to accelerate the process of reversal and further strengthen the epidemic response in India among the IDU by scaling up of OST centres in the coming years.

[1] DAC NEWS (A Newsletter of the Department of AIDS Control) Vol.X Issue 1 October 2013-March 2014. MoHFW

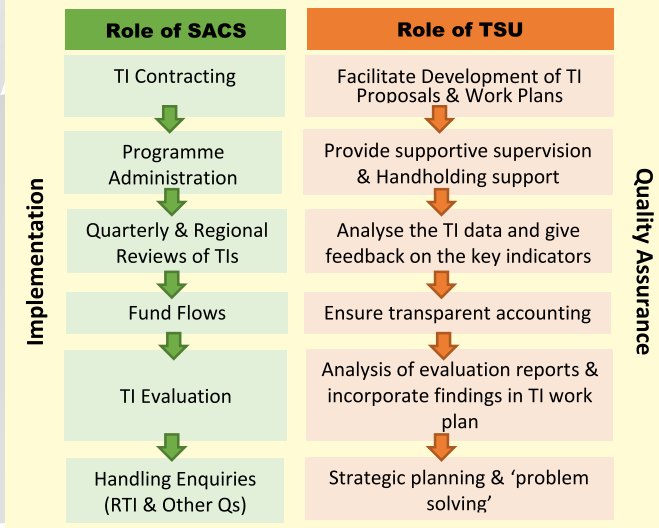
14. Institutional Mechanisms for Technical Support

Context and Challenges

The National AIDS Control Programme (NACP) in its third phase during 2007-2012 had set ambitious targets for scaling up operations in all of its key implementation areas. To achieve a high level of coverage and maintain quality of programme implementation, the National AIDS Control Organisation (NACO) identified consultants having strong management and human resource capabilities to set up 'Technical Support Units' (TSUs) for support, development and implementation of HIV/AIDS strategies. TSUs provide handholding support for non-governmental organisations (NGOs) and community based organisations (CBOs) implementing TIs at the ground level as well as care and support initiatives in the state. They provide technical support in other areas as and when required by State AIDS Control Societies (SACS).

A need was also felt to converge NACP with the National Rural Health Mission (NRHM) to ensure standardised STI/RTI service delivery through all sub-district facilities for which a joint operational framework was developed. Besides merging with the existing sub-district general health facilities, it was also necessary to decentralise and establish district-level units, where the disease burden was high.

Figure 1: Working Mechanisms of SACS & TSU



The Approach: Developing Strategies

Through the decentralisation and mainstreaming process, NACO set up institutional mechanisms at national and state levels[1]. These include National Technical Support Units (NTSUs), TSUs at State levels and a National Technical Support Group (TSG) for trucker interventions and condom programming. Thus the TSUs created to offer professional expertise in the management of TIs also provide supportive supervision to strengthen the quality of programme implementation.

Figure 1 illustrates how the work of SACS and TSU is structured. The programme management structures (including TSUs and TSGs) were further strengthened to achieve NACP IV (2012-2017) objectives.[2] TSUs of managerial and technical experts, embedded in, but distinct from government, provided support in five key areas: strategic planning; monitoring and evaluation; supportive supervision; training; and information, education, and communication. All states had focal persons to oversee the quality and management aspects of TIs. Overall TSUs assist in a range of programme functions (**Box 1**). *"This model likely contributed to effective and rapid scale up of Karnataka state's HIV prevention program. A clear mandate, close collaboration, and well-defined roles were keys to success"*.[3]

State Training and Resource Centre (STRC): provide training and develop the capacity of TI project staff to implement TIs.

District AIDS Prevention and Control Units (DAPCUs) were set up at grassroots level in high-prevalent districts[4] categorised as A and B to provide management oversight and administrative support for the HIV programme. DAPCU is NACO's lowest administrative structure that works with district administration and programmes provided under the NRHM, with which NACP will eventually converge.

Box 1: Strategies Promoted by NACP through TSUs

Rewards: Rewards in the form of recognition and acknowledgement were used to motivate knowledge sharing among stakeholders

Cross-project learning: The stakeholders were facilitated to learn from people who are carrying out similar interventions

Knowledge mapping: A map of knowledge repositories available in some states was made accessible to all stakeholders

Expert directories: A directory of consultants and experts working in the field of HIV/AIDS was made available to all stakeholders for further interaction

Best practice transfer: Best practices on HIV AIDS prevention and care were transferred for replication

Knowledge repositories: By the way of creating and managing databases of information, Knowledge Repositories were developed to assist in sharing of knowledge

[1] NACO, 2011. Technical Support Units (TSUs) in NACP III.
[2] NACP IV Strategy Document, 2012.
[3] Seema K Sgaier. et al. 2014. *Technical Support Units to Strengthen Government Management Capacity*. Global Health Science and Practice, Vol.2 No.4.
[4] Using the HIV Sentinel Surveillance data (2004-2006), all the districts in the country were divided into four categories (Category A,B,C and D) based on the disease burden. http://www.naco.gov.in/NACO/Quick_Links/DAPCU/

Supportive Supervision and Monitoring: Under NACP III, NACO developed operational guidelines for TIs covering management of NGO/CBO procurement, NGO finances and TIs. NGO proposals are scrutinised by an expert committee and final approval is granted by an executive committee constituted at state level to monitor the overall HIV state programme. NGOs and CBOs selected by transparent processes, work under clearly defined contracts and deliverables. At the same time, a strong component of monitoring and evaluation has been built in as an integral part of the TI to capture the progress of the project and obtain feedback on its efficiency and effectiveness. Monitoring systems and protocols make it possible to understand needs and analyse available data to assess impact.

"One successful model is the development of a TSU to infuse government bodies with high-level evidence-based program planning and oversight capacities. The benefits are two-fold: the capacity of civil servants is improved while the HIV/AIDS programs they manage are more effective and cost-efficient".

India Operational Plan Report FY 2011, PEPFAR

Annual Evaluations: An independent annual evaluation is an inbuilt mechanism to see the progress of the NGO TI, identify gaps for further strengthening and ensure handholding. NACO's standard tools and manuals ensure the uniformity of evaluation by trained external consultants across the country, including programmatic, management and financial aspects. The extension of contracts with NGOs is based on the recommendations of evaluations.

Evidence-based programming: Data generated and analysed provides field intelligence that informs programme planning and design.

A TSG for condom promotion was formed to assist NACO in designing, implementing, monitoring and evaluating the national condom promotion programme. The TSG structure included 10 people managing the overall programme, operation, communications, research and finance based in Delhi, 4 regional and 22 State marketing managers based at State AIDS Control Societies (SACS). The TSG was set up with the objective of easy management of the social marketing of condoms to meet the objectives of the NACP.

Results

NACO has strengthened its institutional capabilities by setting up Technical Support Units in 17 States. By June 2010, DAPCUs were set up in 189 high HIV prevalence districts. Currently 17 State Training Resource Centres provide training to TI staff using standardised modules. There are 18 technical resource groups (200 experts) which provide technical advice to divisions for all major programmatic areas.

"The TSUs, overseen by a National Technical Support Unit, will continue to play a vital role in improving and ensuring the quality of TIs. The TSUs operate in coordination with TI Division of DAC/NACO and SACS. Lessons learned from NACP III show that this synergy has contributed to improving the quality and future capacity building within SACS and DAC/NACO will be enhanced for ensuring sustainability."

Project Appraisal Document for NACSP (NACP IV), World Bank

This has resulted in better quality through improved analysis of surveillance data and other indicators to re-prioritise HIV prevention programmes and services. Comprehensive strategies were developed to support scale up towards saturated coverage of KPs. Tracking and reporting for effective programme monitoring was enhanced. Challenges in implementation and problem solving were overcome. Finally, the setting up of knowledge resource centres (KRC) have helped in easy sharing of information, cross-learning between partners, details of experts as well as best practices.

Innovation is an important aspect promoted through strengthening institutions. Sixty nine DAPCUs from 16 states reported innovative activities such as adolescents school health programme, raising funds from local private sources and linking people living with HIV in the district to social benefit schemes. In 32 districts, DAPCUs linked more than 60 per cent of PLHIV to social benefit schemes.[5]

[5] NACO, Nov 2012. Assessment of DAPCUs.

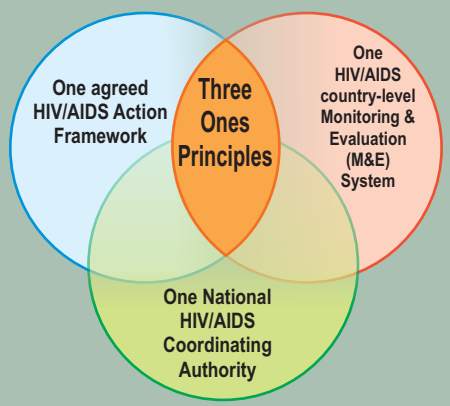
15. Adopting the 'Three Ones' Principles in India

Context and Challenges

The beginning of the 21st century saw a sharp increase in the global response to HIV/AIDS when funding for programmes in developing countries went from USD 300 million in 1996 to USD 6.1 billion in 2004.[1] However, increased funding did not fully translate into solid outcomes. Some funds remained unused because of lack of mechanisms to set it in motion. In other cases, it was not optimally spent due to the lack of coordination between international, national and community-based actors, which caused parallel financing, planning, programming and monitoring of interventions. As stated by UNAIDS, it thus became clear that 'there was an urgent need to increase the capacity of developing countries to use the available funding efficiently and effectively'.

Initially, presented by UNAIDS at the International Conference on AIDS and sexually transmitted infections (STI) in Africa in 2003, the 'Three Ones' Principles was endorsed in Washington D.C. on 25th April, 2004, by major bilateral donors, UNAIDS Co-sponsors, key international organisations and national governments (**Figure 1**). This endorsement helped reinforce the commitment of international stakeholders to coordinate

Figure 1: Three Ones Principles



contributions to the HIV epidemic at the national level with the twin goals of scaling up the national HIV response and strengthening programme coordination. The challenge was in effectively adapting the 'Three Ones' Principle to India's National AIDS Control Programme (NACP).

As stated by National AIDS Control Organisation (NACO), the intent of the 'Three Ones Principle' is to support coordination. It does not intend to restrict innovation or limit the ability of implementers to tailor their response to meet local needs. The key concept is for all State AIDS Control Societies to maintain a minimum set of standard indicators which are augmented by additional, state specific requirements for programme monitoring. **Box 1** captures the 'Three Ones' in India.

Box 1: India's Adaptation of the 'Three Ones' Principles

1. The NACP III Programme Implementation Plan (PIP) was the blue print for implementing the National AIDS Control strategy
2. NACO is the national Coordinating Authority
3. The NACP III M&E framework set critical monitoring and evaluation parameters, endorsed by stakeholders

The Approach: Response and Solutions

1. Adoption of a Common HIV/AIDS Action Framework: Recognising the need to strengthen the national framework and its monitoring and evaluation capacities, NACO in 2006 ensured that all stakeholders, including donors, were brought on the same page and planning was done through a series of consultations. Over 60 working groups met and deliberated to come up with one agreed national framework. NACP III adopted the 'Three Ones' as one of its guiding principles in strategy development. The strategy document notably mentions that NACO will work with its development partners at the national and state levels 'through the establishment of a coordination framework enjoining each to the spirit of Three Ones'.[2] Towards this, NACO established a Donor Coordination mechanism in order to: a) Prevent duplication and maximise effort, resources and impact; b) Share information on action plans; c) Improve coordination at all levels and strengthen programme harmonisation; d) Ensure clear data collection and e) Jointly review programme performance on a quarterly basis.

2. Establishment of One Coordinating Agency: NACO has been the nodal organisation for formulation of HIV/AIDS policy, programme implementation and coordination since 1992. Key activities for strengthening its strategic information management included: 1) Reviewing and validating information for planning and programme implementation; 2) Strengthening programme monitoring to provide more accessible information; 3) Enhancing surveillance systems to provide data at the state and district level; 4) Reviewing models used to generate various state and national estimates on the basis of surveillance data; and 5) Supporting independent evaluation and research.

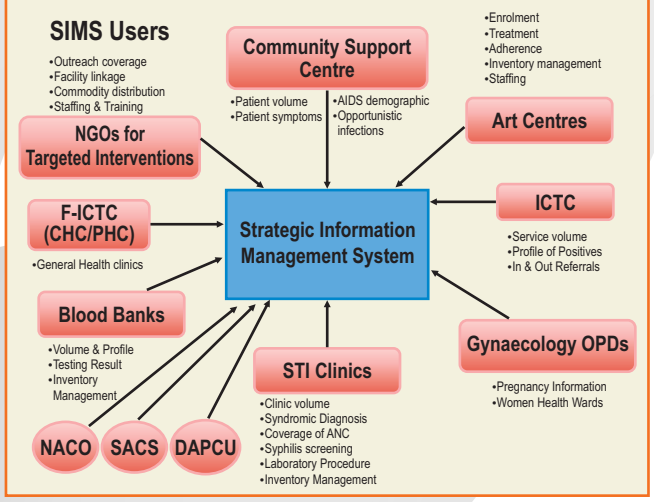
3. Establishment of one National M&E Framework: Towards the end of NACP II (1999-2006), NACO coordinated the development of a solid framework for a national monitoring and evaluation system in accordance with the 'Three Ones' principles. The existing Strategic Information Management

[1] UNAIDS. 2005. *The "Three Ones" in action: where we are and where we go from here.* p.12
[2] NACO, 2007. NACP III, To halt and reverse the HIV epidemic in India. p.25

System (SIMS) was strengthened to complete the UNAIDS 'Ones trilogy.' (**Figure 2**) To do so, NACO, during NACP III, introduced three strategic shifts in data collection and analysis:

a) Establishment of the basic rules, definitions and operating procedures for a strong M&E, not only to monitor epidemic

Figure 2: The Strategic Information Management System



progression, but also to track the performance of the national programme.[3] b) The introduction of SIMS Units at national and state levels dedicated to maximising the effectiveness of available information and implementing evidence-based planning.[4] c) Enhancement of the Computerised Management Information System to address existing gaps and add features to support decentralisation to the district level. It also augmented the capacity of primary data reporting units and programme managers at national and state levels for evidence-based planning and monitoring.

Having a strong SIMS was a high priority agenda under NACP III. In fact, it was one of the four key strategies of NACP III which is being further consolidated and strengthened during the current phase of NACP IV. This is manifest from the successful HIV/AIDS Control Programme in India with its system of evidence-based planning, implementation and management.

Results

Upholding the essence of the Three Ones Principles in India, NACO has worked in close coordination with development partners at national and state levels. **Box 2** lists the key initiatives under NACP IV (2012-17).

The SIMS Unit has ensured tremendous increase in overall reporting status from 46% in 2006 to 80% in 2013-14.[5]

Through automation, component-wise reporting and the consistency of data has improved considerably. For the same period, reporting is 89% in Integrated Counselling and Testing

Box 2: Key Initiatives in NACP IV under SIMS

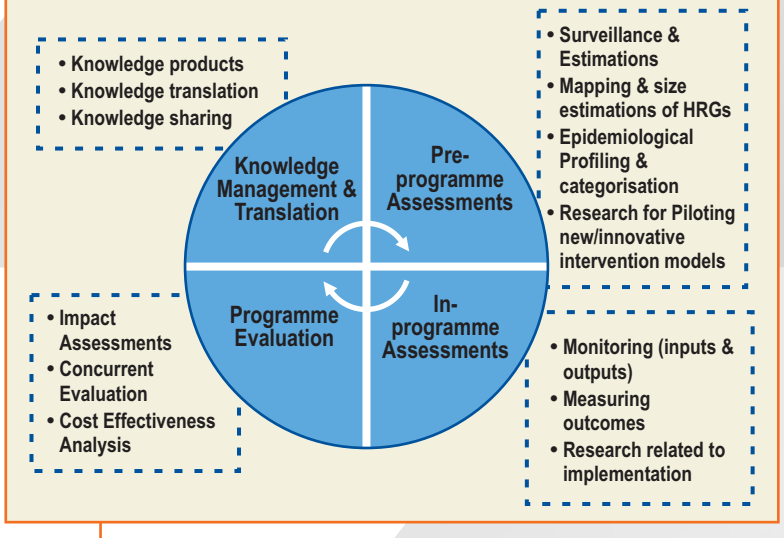
1. National Integrated Biological & Behavioural Surveillance (IBBS) among HRGs
2. National Data Analysis Plan
3. National Research Plan
4. Transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System (GIS) capabilities
5. Institutionalising Data Quality Monitoring System for routine programme data collection
6. Institutionalising data use for decision making

Centres (ICTC), 71% in Facilitated ICTC, 78% in sexually transmitted infections, 72% in Blood Bank, 87% in Targeted Interventions for female sex workers and 78% in Targeted Interventions for Men who have sex with Men. With most donor programmes having transitioned to the government, NACO is fully compliant with the 'Three Ones' and is continuing to strengthen efforts to halt and reverse the HIV/AIDS epidemic.

Experiences and Lessons Learnt

By adapting the 'Three Ones' and in light of the success achieved in controlling the HIV epidemic in the last eight years, NACP IV has given highest priority to 'Knowledge Translation' in its Framework (**Figure 3**) as an important element of policy making and programme management at all levels.

Figure 3: Framework for Strategic Information



The new M&E system addressed the challenges pertaining to multiple sources of data, varied data collection tools and lack of clear quality control measures. This unified system ensured that data could be synthesised to develop a strategic approach in order to arrive at ***'a more comprehensive and integrated understanding of both programme results and their impact on the epidemic.'***[6]

[3] NACO, 2007. Monitoring & Evaluation: National AIDS Control Programme, Phase-III, India. New Delhi: p. 14.
[4] NACO, 2007. NACP III: To halt and reverse the HIV epidemic in India. pp.22-23
[5] NACO Annual Report 2013-14. p.110
[6] NACO, 2007. Operations Manual for Strategic Information Management Unit. p.10

16. Breaking Barriers through Decentralisation

An Indian Experience in HIV Prevention

Context and Challenges

The effective management of a national programme in India is a challenge, due to the numbers and varieties of administrative and linguistic areas. With 29 States and seven Union Territories, India represents a country of great socio-cultural diversity. The emergence of the institutionalisation process is an example for evidence-based planning of a decentralised national management structure. This was achieved through the building up of national, state and district-level mechanisms. The needs that emerged from different parts of the country were addressed in a timely manner, with system strengthening included as a cross-cutting agenda. Thus by providing techno-managerial and resource support for quality assurance, the National AIDS Control Programme (NACP) became a successful, replicable model for epidemic control from NACP II onwards.

The Approach: Response and Solutions

The National AIDS Control Organisation (NACO) was established in 1992 by the Ministry of Health and Family Welfare, Government of India to take appropriate action on issues of HIV/AIDS. It was initially headed by a senior government official with the rank of Additional Secretary. During NACP I (1992-1997), the main activities of NACO and the State AIDS Cells were awareness creation programmes. In NACP II, "*the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralised response and to increasing the involvement of NGOs and networks of People Living with HIV (PLHIV)*".[1]

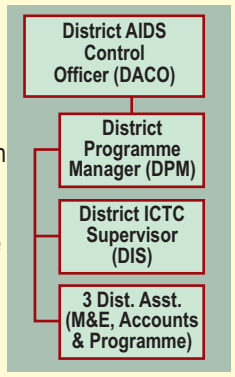
Box 1: Tamil Nadu's Pioneering Efforts

India's southernmost state, established the first Tamil Nadu State AIDS Control Society (TANSACS) in 1998 for state level coordination of NACP. NACO then decentralised HIV prevention programmes and efforts to TANSACS at Chennai. Both effectiveness of the programme and coverage of key population increased rapidly. Subsequently NACO decentralised it to all the states for easy and effective programme management.

The creation and structure of TANSACS was found to be more effective as it brought about functional autonomy as well as rapid decision making to address emerging challenges (**Box 1**). Hence NACO facilitated the replication of State AIDS Control Societies (SACS) in all states during NACP II. An autonomous body listed under the Registrar of Societies Act, the governing board of SACS is chaired by the State Health Minister, Chief Secretary or a Health Secretary as per decisions taken by respective state governments. As the state-level programmes grew in size, the requirement of more managerial skills emerged in different SACS. Scaling up of NACP, adding more components and service outlets like Targeted Intervention (TIs) Programmes, Integrated Counselling and Testing Centres (ICTCs) and Anti-Retroviral Therapy (ART) Centres, resulted in the need for more effective administrative, reporting and monitoring mechanisms. SACS were restructured with the establishment of Administrative, Finance, Communications, Basic Services, Blood Safety and Surveillance/M&E divisions during NACP III.

Box 2: DAPCUs - Structure and Roles

District AIDS Prevention and Control Units (DAPCUs) have been established from 2008 onwards in high priority districts across the country as a step toward decentralisation of the management of NACP. DAPCUs have been trained and mentored to perform the challenging task of coordinating and monitoring NACP activities. The district administration took up district-specific initiatives by leveraging local resources and getting involved in implementation of the HIV programme.



Based on HIV prevalence, districts were categorised into A, B, C and D. Through the establishment of DAPCUs (**Box 2**) in A and B category districts with high HIV prevalence, the district administration started implementing the HIV programme. DAPCUs were further strengthened with necessary infrastructure, human and financial resources. This not only improved efficiency but helped in delivering much needed administrative support including quick turn around times for approvals and reporting. Technical assistance was provided with the formation of Technical Support Units (TSUs) at SACS level to improve professional standards and quality of coverage.

Efforts for decentralising the technical dimensions of TIs also followed a systematic process. Working with key populations like Female Sex Workers, Men who have Sex with Men, Injecting Drug Users and Transgenders in partnerships with

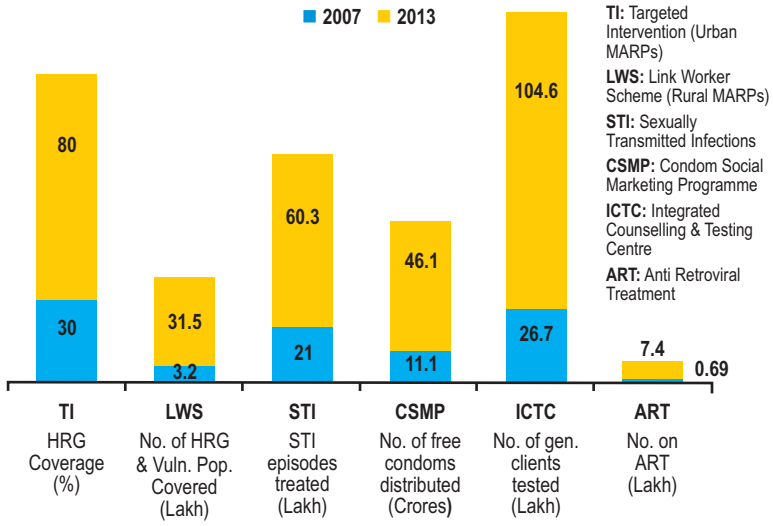
[1] NACO, 2011. Response to HIV epidemic in India. p.12

Non-Governmental Organisations (NGOs) was another challenge. In 1998 an NGO Advisor position was created in every SACS to facilitate partnership building to scale up TIs among High Risk Groups (HRGs). Since 2008, TSUs provide monitoring support and technical assistance to TIs on a regular basis and State Training and Resource Centres (STRCs) provide capacity building to staff of TIs and to facilitate research in HIV programmes. These decentralised supported structures were essential in enhancing quality at all levels.

A National Technical Support Unit (NTSU) was established to provide technical support to TIs through TSUs.

Transfer of programme ownership to communities has been the cornerstone of the decentralisation process, thereby enhancing efficiency and improving coverage. Community Based Organisations (CBOs) of members of HRGs which are more vulnerable to HIV infections have emerged and been strengthened **(Box 3)**. A pioneering step that India took was to build networks of PLHIVs which increased programme effectiveness and reach.

Chart 1: Scale-up of Service Delivery



Box 3: CBOs of HRGs

Transferring the ownership of the programme to CBOs resulted in beneficiary groups taking higher levels of ownership at planning, implementing and reviewing stages. This reflected a quality scale up of TIs among HRGs and care and support programmes among PLHIVs.

Results

Scale up through participatory evidence-based planning in NACP led to effective programme management systems which responded promptly to emerging challenges. Decentralisation of management structure allowed functional autonomy right down to the district level (**Chart 1**).

Strengthening peripheral structures: Infrastructure and human resources were developed at SACS, DAPCU and TI levels to implement the NACP. At district and state levels, professionals were appointed as programme officers to create a vertical structure which coordinated HIV prevention, testing, counselling, treatment, care and support services. Earlier, these were looked after by key government officials in addition to their many other responsibilities. Political will and partnerships with professionals improved overall programme management as well as the decentralisation process.

Improvement of data quality and management: Within each DAPCU and SACS technical professionals for data management were assigned and capacitated. This resulted in timely flow of accurate data that improved evidence-based management. Programme reviews conducted by key officials of NACO and SACS enhanced programme quality and helped identify new challenges.

Decentralised planning helped in identifying, prioritising and addressing issues in different thematic areas like prevention, finance and treatment.

Knowledge sharing resulted in an active 'DAPCU Speak', a moderated blog started in February 2012. Various mechanisms used for capacity building, strengthening and sharing experiences of individual DAPCUs have been publicised through social media using NACO blogs, for others to replicate. This practice has encouraged many DAPCUs to document and present their achievements to SACS and NACO.

Experiences and Lessons Learnt

- Administrative and Management Decentralisation improved programme quality, prioritised and enhanced coverage of services in various situations facing challenges from diverse socio-cultural features.
- Community participation augmented programme implementation for marginalised and difficult to reach communities.

17. NACP Structures: Efficiency Through Institutionalisation and Restructuring

Box 1: Key Principles for Restructuring NACP

1. Need to prioritise programmes based on actual HIV prevalence
2. Provide comprehensive services for both prevention and care and support
3. Ensure that the programme penetrates the last mile in both urban and rural settings
4. Decentralise the programme for effective implementation and monitoring

Context and Challenges

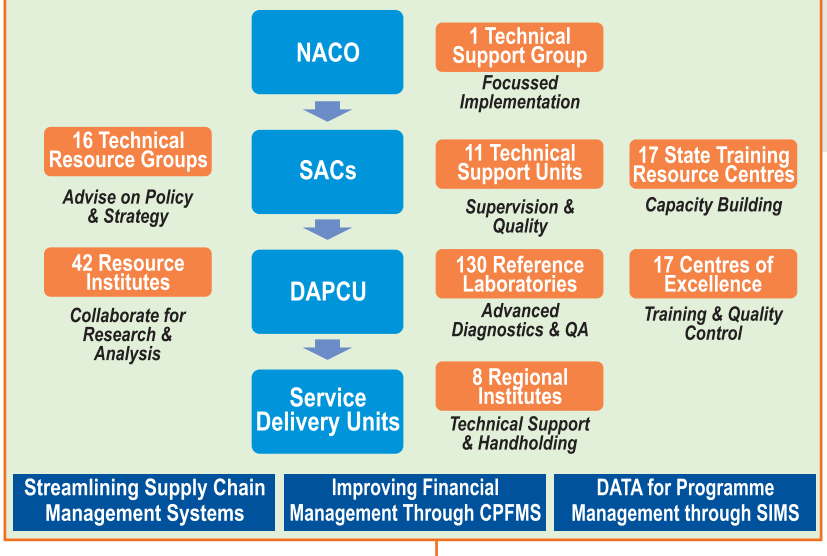
The first case of HIV in India was detected in 1986. In response to the growing HIV epidemic in the country, the National AIDS Control Organisation (NACO) was established in 1992. When the National AIDS Control Programme (NACP) came into being in 1994, it was centrally driven and focused on prevention activities like HIV education and awareness, blood-safety measures, condom promotion, control of hospital infection and strengthening of clinical services. Under NACP II (1999-2006), the process of decentralisation and institutional restructuring began, leading to the registration of State AIDS Control Societies (SACS) in 25 states and 7 union territories. States were categorised based on HIV prevalence (high, moderate or low) so that programme interventions and resources could be customised to their specific situations and needs. To ensure political commitment the National Council on AIDS, comprising of Union Ministers, Chief Ministers and leading Civil Society representatives under the chairmanship of the Prime Minister, was created.

The challenge before NACP III (2007-2012) was the necessity and demand to rapidly expand service delivery, both programmatic and administrative, all the way to the district level (**Box 1**). This required: a) Setting up and strengthening institutions to effectively manage programmes from national to state and further down to district level and b) Restructuring HIV related programmes to improve efficiency of service delivery to achieve targets.

The Approach: Response and Solutions

NACP III was launched with the goal of halting and reversing the epidemic in India through scaled-up focused prevention, access to treatment for people living with HIV (PLHIV), improved infrastructure, systems and human resources at all levels, and a nationwide Strategic Information Management System. This massive expansion in scope and reach necessitated institutional strengthening and restructuring with a conscious shift from a national response to a more decentralised yet convergent and comprehensive district-driven response.[1] **Figure 1** presents the institutional framework for scale-up under NACP III and IV to streamline supply chain management, financial management (through **Computerised Project Financial Management System**) and overall programme management.

Figure 1: Institutional Framework for Scale up



A. Institutional Restructuring: NACP III planned internal re-structuring to form six divisions in NACO with teams to focus on: (a) Basic services (b) Blood safety (c) HIV prevention (d) Treatment care and support (e) Information, education, communication and mainstreaming and (f) Monitoring and surveillance. A separate autonomous Department of AIDS Control (DAC) was created within the Ministry of Health and Family Welfare. Broadly the structures can be classified as:

1**. Administrative Structures:** At the national level, **NACO** leads the AIDS control programme. At state levels, autonomous **State AIDS Control Societies (SACS)** are led by a governing body headed either by a Minister or the Chief Secretary with representatives from government, civil society, trade and industry, private sector and PLHIV networks. They are responsible for implementation of all HIV related services as well as administration, planning, coordination, monitoring and evaluation, finance and procurement. **District AIDS Prevention and Control Units (DAPCUs)** have been established in 189 districts of

[1] NACP PHASE IV, Powerpoint on NACP

22 states, with high and moderately high HIV prevalence. DAPCUs coordinate and monitor service delivery as part of planned decentralisation. DAPCUs play a key role in integration of NACP with the National Health Mission (NHM), and mainstreaming with ministries and industry. They also provide technical support to Integrated Counselling and Testing Centres and coordinate between other facilities.

2. Support Structures: NACO's Technical Support Unit (NTSU) and Technical Support Units (TSUs) were established to provide technical support to NACO and SACS respectively in order to achieve coverage, meet targets and maintain quality of programme implementation. They are consultant bodies having strong management and human resource capabilities at national and state level. Policy making, capacity building of programmes, financial management and strengthening data management are also guided and supported by advisory bodies (**Technical Resource Groups**), capacity building institutions (**State Training Resource Centres** and **Centres of Excellence**) and research and quality assurance bodies (**Research Institutes, Reference Laboratories**).

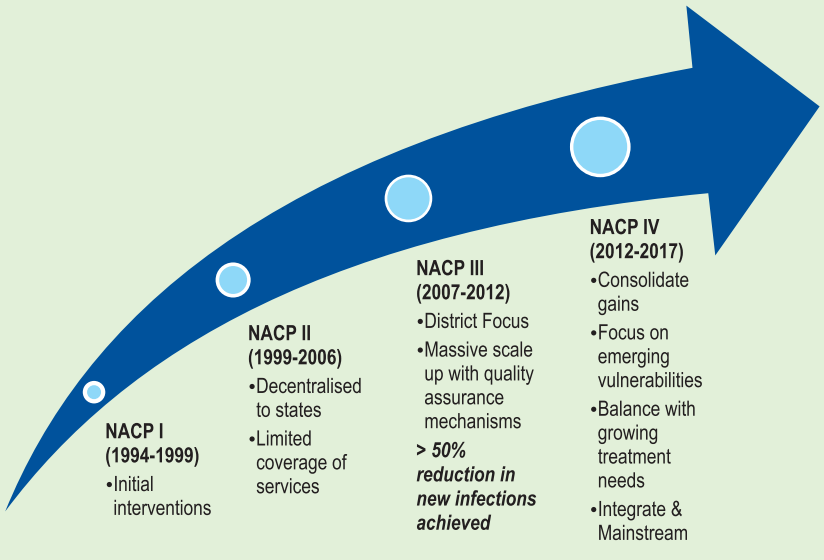
B. Programme Restructuring: With more clarity on the epidemiological drivers of HIV in India, NACO recognised the need to realign programme components into six specific divisions as mentioned above. Each has separate teams to plan and budget programmes and monitor progress. Targeted Interventions, the flagship prevention programme, receive in-house technical support from NTSU and respective state TSUs. Integration with public health care systems, particularly National Rural Health Mission and models of public-private-partnership with industry enhance the mainstreaming of HIV programmes. Coordination between different institutional mechanisms is ensured through developing an Annual Action Plan from district to state level which is approved nationally by NACO.

Results

Having evolved over the years, NACP structures have enabled massive geographical and programmatic expansion with improved performance at all levels. This very detailed, comprehensive, multi-centric and multi-purpose programme addresses different aspects of HIV – from prevention to treatment and care, to strategic information management that feeds into future planning. Standardised medication protocols, operational guidelines, training modules and monitoring mechanisms ensure that quality of services and analysis of progress is scientifically driven.

The whole process of institutionalisation and reorganisation through four phases of the NACP (**Figure 2**) brought in added human resources and technical skills at all levels, significant increases in infrastructure and assets and a great deal of coordination and integration.

Figure 2: Evolution of India's National AIDS Programme



Experiences and Lessons Learnt

Efficient administrative structures and effective support structures add value to HIV programming by supporting scale up while maintaining quality of programmes. The meticulous planning process for NACP III and more recently, NACP IV is a testimony to the commitment and responsibility of the government and civil society in relentlessly pursuing India's commitment to halt the HIV/AIDS epidemic.

18. Peer Education: Reach the Unreached

Context and Challenges

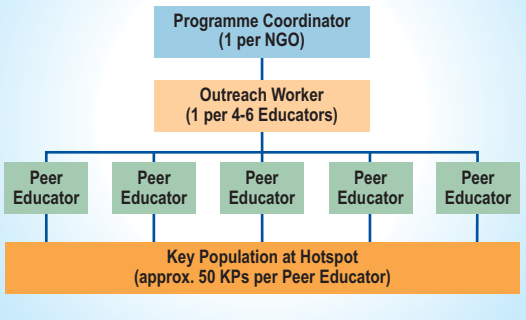
Peer education is an approach to health promotion, where community members themselves share information and values with others who have similar social backgrounds and life experiences.

From 2004 onwards, the focus of the National AIDS Control Programme (NACP) was to up-scale and saturate its reach among High Risk Groups (HRGs) like Female Sex Workers (FSW), Men who have Sex with Men (MSM) and Injecting Drug Users (IDU), with clearly worked out strategies, defined targets and planning outreach tools. As hidden groups, these populations had to first be identified and estimated before interventions began, and only then targets set for outreach and prevention services. At the beginning of NACP III in 2007, plans were made for universal coverage of HRGs. Strategies were developed to identify, map HRGs and set up Targeted Interventions (TI) for HRGs. It was recognised that though HRGs had the highest risk of contracting and transmitting HIV, they also had the least access to prevention, care, and treatment services because their behaviour is often stigmatised, and even criminalised.[1] It was in this context that selecting, training and appointing members of those communities as peer educators (PEs) for outreach and implementation, became a key strategy of the HIV prevention programme.

The Approach: Response and Solutions

A peer education programme is initiated by health professionals, who recruit members of the 'target' community to serve as PEs. A PE is often selected during the initial days of the project based on their interest, motivation and ability to mobilise their peers to participate. It is not really necessary for PEs to have formal schooling or be well-versed in issues related to the programme – in this case prevention of HIV transmission.

Figure 1: Typical Management Structure for Peer Led Outreach



Once identified and designated as a PE, it is the responsibility of the TI to train them in their respective areas of work. Very often, one PE is taught to handle different components of the TI like identifying other community members, interpersonal communication, condom education and motivating their peers to access the services. Referrals are directed by PEs to the Integrated Counselling and Testing Centre (ICTC), Drop-in Centres (DICs) and Sexually Transmitted Infection clinics. Once trained in the relevant health information, the recruited PEs then engage their peers in conversations that seek to promote health-enhancing knowledge and skills. The assumption is that peers, giving locally relevant suggestions, in their regional language, will most likely promote health-enhancing behaviour change.

Peer education occurs in a variety of settings and includes many different activities. While the basic aim of the programme is halting and reversing the march of the HIV epidemic, peer education itself can be divided into various small sub-components like initiating interpersonal communication, demonstrating and promoting condoms, motivating behaviour change activities, and mobilising community members for uptake of services.

The PE is assigned a specific geographical area and a target number of community members to reach out to, in a specified time frame. The numbers will vary depending on the location and the distance a PE has to cover.

Figure 1 depicts the management structure of a TI using peers. In NACP IV (2012-2017), in the FSW and MSM TIs, each PE caters to the needs of 60 community members while each Out Reach Worker (ORW) has four peers under him and reaches out to 250 members. In the TIs for Transgenders and IDU, the ratio for peers is smaller at 1:40 and larger for ORWs where it is 1:200. For migrants one peer caters to 700 members and one ORW to 2,000

[1] http://www.popcouncil.org/research/key-populations-at-risk-for-hiv

members while for truckers one peer caters to 1,000 members and one ORW to 2,500 members. Furthermore, National AIDS Control Organisation created clear-cut guidelines for unit-wise TI costs, which are uniformly implemented across all TIs for different HRG and bridge populations across the country.

During the first phase of the peer education programme, state lead partners and local implementing Non Governmental Organisations are contracted. Then peers are trained to conduct mapping. Once the size of the high-risk population is estimated, the peer outreach network is established.

In the second phase, services are rolled out. Micro-planning enables peers to analyse gaps in service delivery and prioritise outreach. Roles of the peer from educator to case manager for HIV prevention are defined. Assessment of the quality of peer interaction with community members takes place. Monitoring of the number of condoms distributed and the number of clinic visits is supplemented by field visits, so that the relative impact of interactions and 'opportunity gaps' in service levels by peers can be understood.

In the third phase, PE capacity is enhanced to cultivate them as opinion leaders and change norms of behaviour in the community. Peer outreach expands from risk reduction to addressing underlying vulnerabilities. High-risk individuals are linked not just to services but to crisis response systems, local advocacy efforts and community groups. Peers from different geographic areas learn from one another across districts and states. *"Peers are increasingly becoming community leaders, who set norms for health-seeking behaviour and act as role models. They practice safe sex, go to the clinic, and take initiative to tackle community priorities."*[2]

Box 1: Factors contributing to an enabling environment

Capacity Building: TIs build peer capacities through clearly defined and scheduled modules on different programme components

Building Sustainability: PEs promote programme sustainability as they are recruited from local communities. They are both recipients and effective promoters of services as they have experienced their benefits

Setting Achievable Targets: PEs are able to reach and mobilise hidden, unreached community members. One factor that consistently improved coverage was setting achievable outreach targets that were grounded in reality

Results

Community-led intervention: The key populations have become the foot soldiers for the complete prevention programme in the country with PEs being the prime movers. Not only have they made the TI more effective, but also more sustainable in the long run. Later the experienced and committed PEs are considered for managerial posts in the same project, which highly motivates them and ensures sustainability of the efforts.

Improvement in scale and intensity: Empowering peers and capacitating them to participate in micro-planning of outreach went a long way in improving scale and intensity of the programme. By virtue of being familiar with the working patterns of community members, PEs were able to prioritise their work in time-saving and cost-effective ways.

Creation of Community Leaders: PEs, who came into TIs as mere communication facilitators, have over the last two decades, transformed themselves into community leaders, where their roles extend far beyond the scope of disease control. As community advisors they are a crucial link between community members and TI projects.

Access to Services: PEs are central to service delivery through whom the programme has achieved over 82.7% coverage - over 0.7 million FSW and about 0.3 million MSM as of March 2014.[3]

Experiences and Lessons Learnt

Peer education relies heavily on volunteers as PEs do not get a salary but are paid an honorarium of INR 3,000 (USD 50) monthly. Adequate motivation and a decent monetary compensation will help in retaining PEs. Due to HRGs being prone to migration, both retention of PEs as well as effective monitoring and evaluation has proven to be a challenge. To address this, more PEs are continuously recruited from the community.

Internal dynamics of groups and members has to be taken into account while designing the peer education programme. This is especially so while working with transgender communities, where hierarchy within the group is clearly defined. In such contexts, senior members may find it difficult to 'learn' from peers, who are considered their juniors or subordinates. Peer training and capacity building played a key role in the success of the programme and it needs adequate amount of time and resources.

[2] Avahan, 2009. Peer Led Outreach at Scale: A Guide to Implementation.
[3] NACO Annual Report 2013-14. p.12

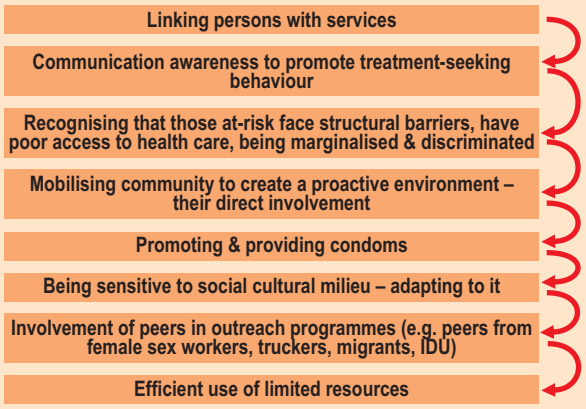
19. Community Led/Initiated Communication Material

Box 1: Communication Objectives of NACP IV

- To increase knowledge among general population (especially youth and women) on safe sexual behaviour
- To sustain behaviour change in key populations (high risk groups and bridge populations)
- To generate demand for care, support and treatment services
- To strengthen the enabling environment by facilitating appropriate changes in societal norms that reinforce positive attitudes, beliefs and practices to reduce stigma and discrimination

Context and Challenges

Figure 1: Purpose of Communication Material



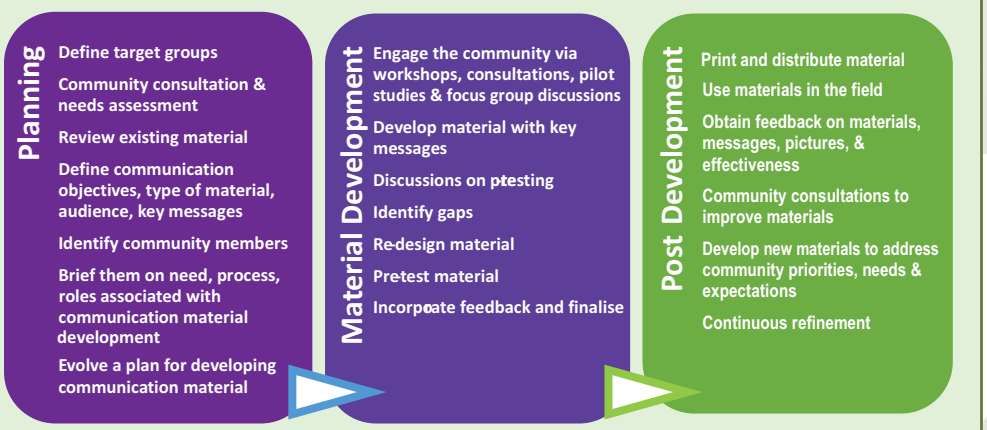
Community initiated and community designed communication material has been developed in line with the communication objectives of the fourth phase of the National AIDS Control Programme (NACP IV) to sustain behaviour change among High Risk Groups (HRGs). An integral part of the multi-dimensional strategy adopted by NACP IV has been its Information, Education and Communication (IEC)[1] and Behaviour Change Communication (BCC) components (see **Box 1**). This material was intended to change stigmatising and discriminatory attitudes and motivate access to testing, treatment and support.

Targeted Interventions (TIs) for hidden, marginalised HRGs have kept in mind the local context and problems on the ground to create a sense of ownership and involvement. The community being at the centre of the process of initiating, designing and revising material with technical support, ensured that communication material was relevant, non-stigmatising and contextual to problems on the ground (see **Figure 1**).

The Approach: Response and Solutions

Community led approach: With community participation in the form of interviews with key persons, focus group discussions with stakeholders and workshops, consultations, IEC and BCC materials have been developed keeping in mind regional, cultural and target group characteristics. For example, NACO guidelines recommend use of visuals, pictures or situations that migrants and truckers identify with.[2] **Figure 2** presents the process of planning, development and refining communication materials.

Figure 2: Process in Developing Community led Materials



Community initiated BCC material: The entire community is engaged in a bottom-up approach to map, build rapport and conduct needs assessment (of HRGs). This led to creation of innovative community-friendly IEC/BCC material which is responsive to community needs and can be used by all levels of stakeholders. Examples include:

- **Community ownership**: The innovative Knowledge Olympics[3] in six high prevalence states in India for cross sharing of knowledge placed communication tools into the hands of those at the heart of the programme. This enabled them to dialogue, share, network and advocate. Teams from the community were trained in filming, photography, public speaking and event management and plays produced were relayed via satellite.
- **Involvement by Female Sex Workers, Men who have Sex with Men (MSM) & Transgenders:**[4] Each typology has its own unique cultural code, language and experiences. As part of teams

[1] *NACO.2012.NACP IV Strategy Document. New Delhi. Ministry of Health and Family Welfare, GOI.P-12*
[2] NACO, 2007. Targeted Interventions Under NACP III, Operational Guidelines/Volume II-Migrants and Truckers
[3] Vichara, 10th edition, Jan 2009. Joint Publication of Karnataka State AIDS Prevention Society & Karnataka Health Promotion Trust.
[4] Community led outreach: An outreach strategy for focused HIV prevention programming in urban sex-work settings in India based on the experience of working with sex worker communities in Karnataka, South India. Manual supported by Bill & Melinda Gates Foundation, under India AIDS Initiative, *Avahan*2010; Setia et al., 2006; Solomon et al., 2010

• involved in programme planning, implementation and monitoring, HRGs develop BCC and IEC strategies that reflect issues that affect their lives.

Pre-testing and refinement of materials: Communication materials are pre-tested, refined and finalised with specific target groups. After printing and distribution for field use, feedback is obtained, leading to continuous refinement of existing materials and the development of new ones.

Stepping Stones[5]: A training package, Stepping Stones, was widely used to address sensitive behaviour issues such as HIV and Sexually Transmitted Infections (STIs), gender roles, alcohol use, traditional practices, attitudes to sex and even death. Designed as a participatory tool on HIV, gender with communication and relationship skills, Stepping Stones has been successfully used in sub-Saharan African countries and adapted for use in Asia.

Involvement by peers and outreach workers: Peer Educators (PEs) from HRGs and Outreach Workers (ORWs) use folk media to engage audiences using their own cultural contexts. Carefully thought-out national folk media campaigns, including script writing workshops synergised key messages and folk tradition. About 44,117 performances in 2013-14[6] disseminated key messages about safe sex, migration, stigma and discrimination, counselling and testing, prevention of Parent to Child Transmission of HIV/AIDS (PPTCT), blood safety and vulnerability of youth. Other innovative material developed by the community were condom jokes, pocket-sized flip books on women's health focusing on STI/HIV, voice-based SMS to effectively communicate with illiterate populations and use of video films on mobile phones for one-on-one interactions with MSM.

"I feel proud that I have been identified and engaged in the process of developing communication materials. Initially, I had a complex... But the team encouraged and motivated me... Slowly I gained confidence and contributed to developing materials. Contributing to my own community members gave me a sense of satisfaction". **– Peer Educator**

Use of Campaigns: Mass and mid-media campaigns on voluntary blood donation, condom promotion, STIs, stigma and discrimination amongst health care providers and PPTCT have used government and private TV channels, radio, advertisements in theatres and newspapers, hoardings, bus panels, pole kiosks and panels in trains.

Results

Community initiated and community led creation of IEC and BCC materials has not only raised awareness among different stakeholders but also contributed to a great extent in changing behaviour. Such involvement and ownership has helped HRGs to internalise behaviour change and create peer role-models, thereby contributing to the overall success of the programme. One contributing factor that led to the distribution of 9.45 million condoms till March 2014[7], was the active use of communication material at every stage in promoting messages on correct and consistent use of condoms and neutralising the stigma attached to condoms. BCC material designed by the community greatly helped in condom negotiation trainings as they were based on the every-day realities of bargaining with clients.

Experiences and Lessons Learnt

Peer facilitators and outreach workers enabled HRGs to use dialogue-based communication or inter-personal communication (IPC), to address barriers to HIV prevention. One-to-one interaction, group interaction and peer counselling enabled critical reflection among the community.

"Initially, I believed in developing communication materials by advertising professionals or agencies.... After the piloted initiative, I realise it is very important to involve the community because they know more than us". **- Out Reach Worker**

Community led processes of IEC: Communication materials produced by and for HRGs, focus not just on didactic behaviour change messages, but also on difficulties faced by their communities, and empowerment related strategies. Dialogues were conducted between HRGs and other stakeholders across districts and states via satellite.

Improved staff capacities through BCC training has helped: (a) Guide community discussions about positive social norms and values, and (b) Identify risk reduction and avoidance strategies. This helps PEs and ORWs to more effectively address HIV prevention issues among target groups and thus builds sustainability.

[5] Operational Guidelines to Implement Stepping Stones in the Community: Developed in the context of Project Samastha (supported by USAID, India, University of Manitoba, Samastha, KHPT)
[6] NACO Annual Report 2013-14. p. 82
[7] *ibid*., p. 37

20. Community Managed Thrift Society Programmes for Reducing Vulnerability to HIV

Context and Challenges

Effective HIV prevention strategies with High Risk Groups (HRGs) necessitate a combination of risk reduction and vulnerability reduction programmes.[1] Standard HIV risk reduction strategies (mainly Information, Education and Communication, Behaviour Change Communication, condom use, Sexually Transmitted Infection (STI) treatment, Integrated Counselling and Testing Centres, Prevention of Parent to Child Transmission services, etc.) are well tailored to HRGs in Targeted Intervention (TI) programmes under the National AIDS Control Organisation. Vulnerability reduction strategies however, focus on advocacy efforts to create an enabling environment and reduce stigma faced by Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TG) and Injecting Drug Users (IDU).

Discussions with communities revealed that most FSW were: a) from poor backgrounds, b) widowed or deserted by their spouse, c) facing migration issues, and d) experiencing financial difficulties. Even while earning an income through sex work, they continue to face harassment from pimps, clients, money lenders and oppression by the police and the general public. Pressures of daily concerns like shelter, children's education and basic entitlements for their families resulted in the need for short and long term financial security. Recognising that socio-economic factors are often both the cause and consequence of high risk behaviour, implementing partner Non Governmental Organisations (NGOs) took the lead in planning and initiating vulnerability reduction strategies to strengthen TI programmes.

Community Voice

"If we cannot even provide safety and security for our children and ourselves, who cares whether or not we get HIV? Maybe dying is better than living this way"!

- FSW near Bangalore

The Approach: Response and Solutions

As part of vulnerability reduction, some implementing NGOs introduced services to address financial needs like savings and credit. Savings was considered a 'Prevention Plus' initiative which would be in addition to the minimum package of services administered by community managed thrift groups. Others formed community self-help groups that linked HRGs to social entitlements, along with their HIV prevention programmes (**Box 1**). It is important to clarify that these strategies were piloted to demonstrate best practices and are not a uniform approach across the country. Rationale suggests that empowering women in the community will lead to economic enablement which in turn will strengthen risk reduction practices. Two case studies highlight this focus on vulnerability reduction measures that ensure sex workers have secure, healthy lives.

Box 1: Community Led Thrift Societies for Vulnerability Reduction

- Mobilisation into small groups
- Initiation of savings and credit activities
- Linkages to vocational training
- Linkages to income generation programmes
- Linkages to banks or Microfinance Institutions (MFIs) for loans
- Co-locating and combining savings and credit activities with HIV prevention services

Case Study 1: The Community Based Organisation (CBO) has a community managed cooperative that provides sustainable access to financial services for women in sex work. It is a collective of FSW and was registered in 2007 under the Karnataka Souharda Sahakari Act (KSSA), 1997 and has 7879 member shareholders with a mission of creating a 'self-reliant, community-owned and regulated financial institution, providing sustainable access to critical financial services to FSW'. It initiated financial products under savings and credit along with welfare and insurance measures for its members. They initiated their services through membership fees and used reserve funds to introduce over ten different products for savings and credit (**Box 2**).

Box 2: Saving Schemes for FSW

- Regular Saving Bank Accounts
- Flexible Recurring Deposits
- Fixed Deposits
- Saving for Children's Marriage
- Saving for Education
- Saving for Gold

Later loans were obtained from NABFINS, a subsidiary of the National Bank for Agriculture and Rural Development and

[1] NACO, 2007. NACP III, To halt and reverse the HIV epidemic in India.

'Friends of World Women's Banking'. Loans were provided under guarantee from the other community members and systems evolved for repayment in time. Loans were given through special Common Interest Groups (CIGs) formed or to individuals (with a 3 member collateral mechanism in place). Several checks were put in place to ensure that recovery would not be an issue.[2]

The CBO has strategically linked HIV risk reduction services to their products. Most women who came to the loan collection centres also received STI services and condoms. The CBO allocates a share of the enterprise's profits towards STI and HIV prevention initiatives. The team has made arrangements to ensure that the visits for health check-ups and HIV prevention services coincide with loan repayments/ financial transactions to maximise efficiency and participation.

2. Case Study 2: This CBO was formed as a federation institution to serve the needs of sex workers who were in smaller grassroot-based support Soukhya groups. Built on the model of the small group concept, Soukhya groups met every week to discuss issues relevant to them, managed their own condom promotion and STI service requirements as well as provided thrift services. The groups are trained to collectively manage savings and credit. The CBO facilitates linkages with banks and financial institutions. At the district level, 68 such groups federated to form a support institution. In turn, they responded to the expressed needs of sex workers ranging from financial linkages for loans for thrift groups, linkages for social entitlements (ration cards, voter identification cards, children's education support, widow and old age pensions), health related services and promoting entrepreneurial activities among women in sex work.

These case studies showcase critical vulnerability and risk reduction strategies that effectively reduce high risk behaviour among HRGs.

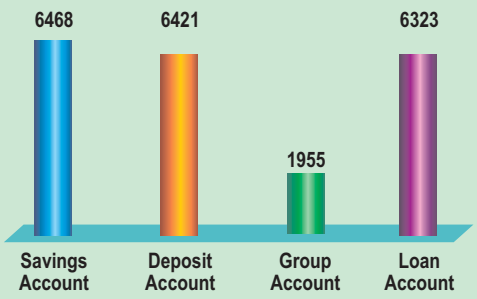
Results

The main impact of thrift societies is that access to secure financial resources has enabled women to save for their children's education, daughter's marriage and buy gold as an asset that they can capitalise on in an emergency. Financial stability with savings and loans have helped sex workers venture into alternate livelihoods and earn additional income.

The CBO supporting FSW broke even in 2011, and now has a reserve of 28 lakhs, with a history of 100% recovery by financial year end.[3] Almost all members have a savings account, several have put money into recurring deposits and long term fixed deposits (see **Figure 1**).

CIGs have availed 125 loans primarily to start businesses (39%), repay co-existing loans (23%), children's education (14%) and for house rentals (13%). Several other service products including insurance, vocational training and job placement are built into their portfolios.

Figure 1: Access to Savings and Credit for FSW



They have secured a total loan amount of INR 5,134,900 (USD 85,582) from banks and Micro Finance Institutions and ensured timely repayment of loans. Apart from becoming more financially secure, women have created opportunities for alternative employment through savings, availed loans and gained social acceptance. The combination of vocational training and business loans helped build alternative livelihoods that reduced vulnerability among members (**Box 3**).

Box 3: Community Success Story

A widow who is also a sex worker having two polio affected children, joined a thrift society. She took a loan to buy a cow. Today she makes a profit of INR 20,000 (USD 330) per month owning eight cows and a vehicle to transport milk to the local dairy. She is proudly referred to as the 'V J Kurien' of the CBO (after India's famous founder of the Milk Amul Cooperative) by her peers. With her additional source of income, she says she not only refuses sex without condoms but chooses to have fewer clients and is very regular with her medical checks to 'live healthy and live well'.

Further, there has been increased uptake of HIV prevention services from the TI along with improved health consciousness. Women have taken greater responsibility for the education and health of their children and come together to prevent children from being pushed into the sex trade.

Most importantly, FSW feel empowered to take ownership of the HIV prevention programmes. They strongly support each other when faced with violence, oppression and in tiding over crisis situations.

Experiences and Lessons Learnt

Vulnerability reduction initiatives that build financial security also promote HIV risk reduction because of simultaneous access to savings and HIV prevention services. The most important factor for the success of both thrift management models is that the community owns and manages them. Both case studies are excellent, replicable models of empowered CBOs taking ownership of risk and vulnerability reduction programmes.

[2] Interviews with the Board Members of Swati Jyoti on January 23, 2015
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- MIS at Targeted Interventions Level
- Services for Sexually Transmitted Infections
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- Opioid Substitution Therapy
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- Institutional Mechanisms for Technical Support
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