USAID
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17 YEARS OF EXCELLENCE
APAC PROJECT DOCUMENTATION

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ACRONYMS

AIDS	Acquired immune-deficiency syndrome
ANC	Antenatal care
ANM	Auxiliary nurse midwife
APAC	AIDS Prevention and Control Project
ARC	APAC review committee
ART	Antiretroviral therapy
BCC	Behavior change communication
BMGF	Bill & Melinda Gates Foundation
BMW & IC	Biomedical waste management and infection control
BSS	Behavioral Surveillance Survey
CBO	Community-based organization
CCLS	Comprehensive care and livelihood support
CETC	Continuing education and training center
CHAM	Consortium of HIV/AIDS mitigation efforts
CHE	Community health educator
CHES	Community health education society
CMIS	Computerized management information system
CSM	Condom social marketing
CSO	Civil society organizations
CSR	Corporate social responsibility
CT	HIV/AIDS counseling and testing
DAPCU	District AIDS Prevention Control Unit
DFID	Department for International Development, UK
DPM	District program manager
DQA	Data quality assurance
DS	District supervisor
DiC	Drop-in-center
ESRM	Experience sharing and review meetings
FBO	Faith-based organization
FHI	Family Health International
FSW	Female sex worker
GOI	Government of India
HCP	Health care provider

HIV	Human immunodeficiency virus
HIV+	HIV-positive
HRD	Human resource development
HRG	High-risk group
ICONHSS	International Conference on Health Systems Strengthening
ICRW	International Center for Research on Women
ICTC	Integrated counseling and testing center
IDU	Intravenous drug user
IEC	Information, education and communication
IIT	Indian Institute of Technology
IMRB	Indian Market Research Bureau
INGO	International non-governmental organization
INP+	Indian Network of People Living with AIDS
IPC	Interpersonal communication
ISO	International Standardization Organization
IRT PMCH	Institute of Road Transport, Perunderai Medical College Hospital
KSACS	Kerala State AIDS Control Society
LW	Link worker
M&E	Monitoring and evaluation
MARPs	Most-at-risk populations
MCH	Maternal and child health
MHC	Master Health Checkup
MSM	Men who have sex with men
NACO	National AIDS Control Organization
NACP-III	National AIDS Control Program, Phase III
NGO	Non-governmental organization
NHCRC	National HIV Communication Resource Center
NRHM	National Rural Health Mission
OI	Opportunistic infection
ORW	Outreach worker
OVC	Orphans and vulnerable children
PACS	Puducherry AIDS Control Society
PD	Project director
PE	Peer educator
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS

PMC	Project management committee
PPP	Public-private partnership
PPTCT	Prevention of parent-to-child HIV transmission
PSV	Participatory site visits
R&TC	Resource and training center
RFP	Request for proposal
RHI	Reproductive health infection
RNTCP	Revised National TB Control Programme
RUSE	Reaching unreached sex workers
SACS	State AIDS Control Society
SHCRC	State Health Communication Resource Center
SHDRC	State Health Data Resource Center
SHIRC	State Health Information Resource Center
SHRRC	State Health Research Resource Center
SI	Strategic information
SIMS	Strategic information management system
SMC	Social marketing of condoms
SMS	Short message service
SOW	Scope of work
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STRC	State Training and Resource Center
TA	Technical assistance
TAC	Technical assistance component
TAI	Tamil Nadu AIDS Initiative
TANSACS	Tamil Nadu State AIDS Control Society
TCU	Transition coordination unit
TESPIM	Thematic experience sharing and performance improvement meeting
TI	Targeted intervention
TNHSP	Tamil Nadu Health Systems Project
TOT	Trainer of trainers
TRG	Technical resource group
TSU	Technical support unit
TWG	Technical working group
USAID	United States Agency for International Development
VCTC	Voluntary counseling and testing center

VHS	Voluntary Health Services
WHO	World Health Organization

EXECUTIVE SUMMARY

Over its 17 years, the AIDS Prevention and Control (APAC) Project has played a key role in reversing the HIV/AIDS epidemic in Tamil Nadu State, India. This report highlights the project's achievements, best practices, and innovative approaches to addressing the epidemic between 1995 and 2012. It describes the governance and management systems that were the foundation of the program; key strategies and innovative approaches in HIV/AIDS prevention and care; strategies for working with the private sector; and APAC's systematic approach to providing technical assistance (at the national, state and NGO levels) and to monitoring and evaluation. It discusses the approach to sustainability taken by APAC, which was successful through working with non-governmental organizations (NGOs) to transition them to direct funding by the state. Many of these strategies are replicable and have been adopted at the national and state level.

HIV/AIDS IN INDIA

India is the second most populous country in the world and home to the third largest number of people living with HIV/AIDS. The estimated adult HIV prevalence in India has declined from 0.45% in 2002 to 0.29% in 2008. The estimated number of people living with HIV/AIDS (PLWHA) has also declined from 2.73 million to 2.27 million over the same period. However, there is significant regional variation in the trends of the HIV epidemic. India's highly heterogeneous epidemic is largely concentrated in six states—in the industrialized south and west, and in the northeastern tip. This decline is the result of concentrated efforts by the National AIDS Control Organization (NACO) to improve the planning and implementation of an HIV/AIDS program in the country through evidence-based planning, increased human resources, regular capacity-building support and a strengthened monitoring system. NACO also worked with donors and civil society to ensure that their efforts complemented the national program and the available resources were optimally utilized.

HIV/AIDS IN TAMIL NADU

Tamil Nadu is one of the six high-prevalence states in the country. In 1986, the first HIV case in India was detected at Madras Medical College, Chennai. Between 1995 and 1997, HIV prevalence among pregnant women tripled to around 1.25% (Report on the Global HIV/AIDS Epidemic, 2000). Following this steep incline, the state government acted decisively and the USAID-supported APAC Project launched its comprehensive HIV/AIDS program. Since 2001, sentinel surveillance data has been showing a steady decline among antenatal clinic attendees. The decline in HIV prevalence was the result of concentrated efforts made by NACO to improve the planning and implementation of HIV/AIDS program in the country through evidence-based planning, increased human resources, regular capacity-building support and strengthening monitoring systems. NACO also worked with donors and civil society organizations to ensure that their efforts complement the national program and the available resources are optimally utilized."[1]

While the state has shown remarkable progress in decreasing overall HIV prevalence, prevalence among the most-at-risk populations (MARP) continues to be high. HIV prevalence

[1]Accessed from http://www.nacoonline.org/upload/IEC Division/NACO monographs for Vienna/Final NACO Monograph 1.pdf.

among intravenousdrug users (IDUs) was 16.8%, the third highest of all reporting states; 6.6% among men who have sex with men (MSM); and 4.68% among female sex workers (FSWs).[2]

However, this compares favorably with the national overall prevalence of 0.29% in 2008; and the 2007 national prevalence of 7.41% among MSM and 5.06% among FSWs. The national prevalence among IDU is 7.23% (Ibid, 2007). Overall, these comparisons show the remarkable work done by the State AIDS Control Society (SACS), APAC and other civil society organizations (CSO).

APAC PROJECT: SCOPE AND DEVELOPMENT

Integral to APAC's achievements was a strong, flexible partnership between the United States Agency for International Development (USAID), the Government of India (GOI), and Voluntary Health Services (VHS), an NGO in Chennai. These three parties signed an agreement in 1995 that established the $10 million APAC, to run from 1995–2002. The VHS administered the program, with funding from USAID under agreement with the GOI. The length of the project was extended twice, first from 2002–2007 and then for a final phase from 2007–2012. The total budget for the project was $47.25 million.

> *"Tamil Nadu would not have reached this level of success had APAC not been there"*
>
> —Ms AradhanaJohri, Additional Secretary, NACO

Over the life of the project, APAC's role evolved from leading the design and implementation of HIV/AIDS programming in the state to supporting and providing technical assistance (TA) to the SACS and other players.

The goal of **Phase I** (1995–2002) was to reduce HIV/AIDS transmission. The primary strategy was to promote safe sex practices to the vulnerable and MARP through communication, products (condoms) and services (medical treatment). The project delivered prevention-centered programs in 10 districts. It targeted 48 high-risk urban clusters, working through 35 NGOs. The programs initially targeted FSWs, tourists, truckers, and slum populations.

APAC pioneered and systematized the concept of working with targeted interventions (TIs) and then facilitated its scale-up. The project also focused on targeted communication, focused on interpersonal communication (IPC) through community peer educators (PE). It introduced evidence-based programs, which included the first Behavioural Surveillance Survey (BSS) in the country; the first mapping of MARP in the state; and the first community prevalence study of sexually transmitted infections (STIs). The project increased access to STI services and condoms through a public-private partnership (PPP) for condom social marketing (CSM).

In **Phase II** (2002–2007), APAC's expanded to include 23 of the 28 districts in the state and Puducherry. The program continued to focus on prevention and communication, and reached out to new target populations of MSM, IDUs and bridge populations. It also expanded training for medical practitioners in STI, HIV/AIDS opportunistic infections, in treatment and care, and in sensitizing health care providers (HCPs) to work with MARP. Other important initiatives during the second phase included establishing voluntary counseling and testing at NGO centers to facilitate MARP to seek HIV testing; supporting NGOs for provision of home-based care; and strengthening capacities of HIV-positive networks. The project also emphasized partnerships with the private sector and instituted trainings and transfer of lessons to other states and to national programs.

Phase III (2007–2012) focused on transitioning from implementation to TA. While APAC continued to deliver prevention and care programs in seven districts, it focused increasingly on

[2] HIV Sentinel Surveillance and HIV Estimation in India 2007: A Technical Brief.

national and state TA. Under the guidance of a Transition Coordination Unit (TCU), APAC successfully transitioned its 29 interventions in Tamil Nadu and Puducherry to the SACS by the close of the project. Under the National AIDS Control Program, Phase III (NACP III), NACO established Technical Support Units (TSUs) to support the SACS in implementing specific areas, including TIs. APAC provided TA to the TSUs in Tamil Nadu, Puducherry, and Kerala, as well as to the District AIDS Control Units set up by Tamil Nadu State AIDS Control Society (TNSACS) in high-risk districts. APAC also worked to mainstream the testing for and treatment of HIV/AIDS using a health-systems strengthening approach in collaboration with the Tamil Nadu Health Systems Project—this included setting up state resource centers on strategic information, research and on behavior change communication (BCC).

During this phase, APAC piloted evidence-based innovations to address emerging field issues, including technology-based interventions to reach MARP and the concerned public (the Hello+ helpline and short message service [SMS]-based communication). Evidence-building and the use of evidence for programs continued, including studies on "Reaching Hidden Sex Workers" (2009); "Willingness-to-Pay for Private Medical Services" (2009); a "Facility Assessment of Public Hospitals" (2010), and "Participation in the Master Health Checkup" (2009–2011). APAC also engaged more at the national level, with its experience informing systematic data triangulation, the conceptualization of a national HIV/AIDS communication resource center, and the rollout of the national folk media campaign.

KEY LESSONS LEARNED AND GOOD PRACTICES

The purpose of this report is to highlight some of the major components, innovations, contributions, and lessons learned of the APAC Project. Overall, key factors in APAC's success and lessons learned include the following:

> *"APAC was never an outside organization. It played a catalytic role in bringing down the epidemic and in creating evidences for better programming"*
>
> —Ms GirijaVaidyanathan, Principal Secretary, Dept of Health and Family Welfare, Govt of Tamil Nadu and Chairperson of APAC PMC

Project Management and Governance

- APAC management through a unique structure at the state level, (the Project Management Committee [PMC]), ensured ongoing engagement of the state and national governments and facilitated decision-making. All key institutions were represented. The State Health Secretary Chaired the PMC, with the TANSACS Project Director as co-chair, and the APAC Project Director as Member Secretary ; VHS, NACO and USAID were also permanent members. The PMC met quarterly—this active, regular involvement of all stakeholders was critical to ownership, advocacy, and success of the program.
- Collaborating with government in an equal and active partnership from the start fostered joint ownership and responsibility; and was critical for leveraging resources to support programs at the state and district levels.
- Establishing transparent and robust systems for planning, management, monitoring and evaluation (M&E), and training all NGO partners in these systems was important for effective grant and program management. State and national governments have adopted elements of these systems.
- Investing in partnerships is a good practice that can be replicated. Appointing a strong and well-recognized Indian institution as the prime partner strengthened partnerships at all levels and facilitated the project's transition to the SACS. Partnerships with the private sector and NGOs were founded on clear legal agreements and expectations and supported by regular

meetings and discussion. APAC allocated both an adequate budget and staff time for this purpose.

Prevention and Care Models

- Grounding programs in the community and the use of participatory approaches created strong ownership and promoted social change.
- Sound models for comprehensive TIs with MARP have been developed and can be replicated in other contexts. APAC's process of continuous learning and refining of interventions contributed to the development of these models. This approach was based on feedback from the field and advances in medical knowledge. APAC's TI models were community-based and required long-term commitment.
- The dynamics of sex work constantly change and thus required new approaches to reach out to those in the industry. APAC's pilot initiatives—using mobile phones to reach MARP and speaking with regular clients to identify new sex workers—were low cost, innovative solutions to address emerging issues—and have potential for replication.
- The provision of services in prevention and care for MARP required a multi-pronged, holistic approach to address such issues as stigma and discrimination, legal aid, and social support. These were critical elements that ensured a supportive environment for service delivery and communication. For example, care programs went beyond training and service provision and addressed the social and psychological needs of HIV-positive sex workers—setting up the Orphans and Vulnerable Children (OVC) Trust and supporting People Living With HIV/AIDS (PLWHA) networks.
- Ensuring that MARP access health services regularly in both the public and private sectors remains a challenge. Timing of services, provider attitudes, and MARP perceptions about those attitudes and motivation can be barriers. APAC's engagement of nurses in government STI clinics and involvement of community-preferred private HCPs are good examples for addressing health care issues for MARP and can be replicated.
- Working with government to develop an OVC Trust (the first of its kind) demonstrated the use of state funding to create a sustainable response to the emerging social needs of OVC and their families. (This benefitted 20% of OVC in the state and facilitated other states to adopt a similar strategy.)
- The project's robust and evidence-based BCC have resulted in increased knowledge and attitude changes among different populations. Further, voluntary peer education and graduation of PEs resulted in reaching out to more MARP.

Technical Assistance to Government and Civil Society Organizations

- Appropriate use of technical experts within the government system facilitated evidence-based planning, system strengthening, scale-up, quality assurance, and efficiency in program management.
- APAC's significant role in evidence-building (innovations and research studies) facilitated program improvement and appropriate changes in existing health systems and policy development.
- APAC's team actively participated in state- and national-level review/planning meetings, which contributed to transferring field experiences for replication and scale-up.
- Establishing resource centers, field labs, and demonstration centers led to the systematic transfer of knowledge. They provided opportunities to participate in a structured training program and practice learning in the field. These resources significantly improved the impact of training.

- APAC institutionalized TA within government systems, which fostered greater ownership and sustainability. An example is APAC's current work with TANSACS, Tamil Nadu Health Systems Project (TNHSP), and the Government of Tamil Nadu to develop new resource centers on health communication, and integration of data from different health departments.
- APAC's approach of strengthening local institutions, networks, and individuals as TA providers is a cost-effective and sustainable way to ensure effective and efficient program delivery. Sound, standardized systems for training, mentoring, monitoring, motivating, and exchanging knowledge are key components to strengthening NGOs and HCPs, fostering community ownership, and sustaining behavior change.

Working with the Private Sector

- APAC developed a unique PPP process model. A key component of the process is determining and agreeing on (1) the roles of each partner, (2) the resources committed, and (3) the costs and benefits for each institution in the partnership. This philosophy of investing in private sector partnerships built confidence in the private sector and ensured long-term strategic partnerships.
- Building a robust linkage between NGOs and condom manufacturers ensured regular servicing at NGO intervention sites and a sustainable supply-side distribution. If properly trained, NGOs can help motivate retail outlets to carry condoms and promote linkages with stockists and manufacturers. These initiatives resulted in an increase in the number of outlets distributing condoms and the overall sale of condoms in the state.
- A performance-based cost reimbursement system can be an effective mechanism in developing agreements with the private sector. It was highly effective in improving the supply side of condom distribution.
- Engaging the private sector resulted in leveraging additional resources to address unmet program needs (such as establishing STI clinics near highways and resources for OVC programs). This is particularly critical in resource-constrained situations.
- Creating models for engaging the private sector and facilitating the sharing of health information data between the private and public medical sectors increased understanding of health status within the private health care sector. Involving the community in the selection of private HCPs resulted in increased uptake of services and helped address access issues (for example, the Nakshatra clinics).

Strategic Information and Monitoring and Evaluation

- APAC's systematic process for disseminating its behavioral, facility, and community-based research findings has facilitated the increased use of evidence—influencing policies, strengthening health systems, improving program performance, and mobilizing additional resources for health programs.
- Carefully planned M&E systems, supported by a strong data quality assurance (DQA) system, should be an integral part of program design. This ensures that monitoring is a critical part of the program, with well-designed indicators and an established baseline.
- APAC's innovative M&E system improved program monitoring and was adopted at state and national levels. Innovations include mid-term reviews, experience sharing and review meetings (ESRMs), and participatory site visits (PSVs). The concept of joint financial and technical reviews of sub-grantees improved the flow of funds and accountability.
- Establishment of the Strategic Information Management Unit (SIMU), District AIDS Prevention Control Unit (DAPCU), and TSUs facilitated improved, quality reporting from

field units. These systems supported the effective use of data collation, analysis and interpretation, and dissemination, thereby reducing duplication.

- Piloting the use of technology (such as SMS-based reporting) supported appropriate and timely action.

Transition

- Transitioning programs successfully, in response to new policies or changes in the HIV/AIDS epidemic, required a long-term plan and pre- and post-transition support. Joint planning, consultative process, transparent systems, and continuous follow-up at different stages facilitated a seamless transition of several program components to the state.
- Pilot programs, if disseminated in a timely manner, can lead to successful replication and acceptance by government stakeholders.

The APAC Project, which ends in March 2012, leaves a legacy of program innovations, institutions, governance, management systems, and empowered communities. The diverse experience gained over the past two decades has positioned APAC to explore new horizons in health systems and emerging public health issues. Wider dissemination is needed of APAC experiences and learning, to organizations that are confronted with similar issues and challenges, both within and outside the country.

METHODOLOGY AND STRUCTURE OF THE REPORT

METHODOLOGY

Composed of a team of four experts, the APAC experience documentation team examined the successes, challenges, and experiences of the APAC Project through a literature review, initial meetings, key stakeholder interviews, and site visits. The team first conducted a literature review of relevant APAC Project documents (see Appendix C). Upon arrival in Delhi, the team conducted a three-day team planning meeting; participated in an initial briefing with key USAID staff; and took part in in-briefings with APAC program and technical officers and in interviews with APAC staff and beneficiaries.

The team then split into pairs (Team Leader and Senior Technical HIV/AIDS Expert; Private Sector/Alliance Building Expert and Evaluation Methods Specialist) to complete site visits to NGOs and government offices. The APAC staff identified a variety of sites to show the team in order to underscore the project's range of activities and to highlight successes and lingering issues. During site visits, organizations made presentations to the team members and accompanying APAC staff, after which the team asked questions and met with MARP and HCPs. The team also conducted supplemental key informant interviews with representatives of the Indian and U.S. governments and APAC staff, stakeholders, and partners (see Appendix B for a list of key informants).

Next, the team compiled fieldwork results, with valuable input from USAID and APAC. Due to the nature of the fieldwork conducted, this report focuses on the challenges, successes, and lessons learned in the 17-year project—rather than on recommendations or scientific evaluation (see Appendix D for a complete description of the methodology used to develop this report).

STRUCTURE OF THE REPORT

This report covers only a small part of APAC's 17-year program, focusing on selected innovations and best practices in the project's interventions and systems. A short introduction summarizes the project's overall achievements, which is followed by sections that detail individual aspects of the program.

Section I, the introduction, outlines the key factors in the success of APAC's governance and management system. It emphasizes how the pairing of key policymakers (at the state and national levels) with implementing partners facilitated approvals for program proposals, resolution of problems, adoption of innovative long-term strategies, such as the OVC Trust, and leveraged resources. Partnerships and facilitative leadership were also key aspects of APAC's relationships with its multiple implementing agencies and NGOs. The development of human capital was a major underlying principle of staff management.

Section II outlines the 17-year evolution of APAC's programs for HIV/AIDS prevention and care. It describes the components of what was India's first program to adopt a state-wide, standardized program for HIV prevention targeted at MARP. The section outlines APAC's approaches to improving treatment and care services in underserved districts by filling gaps in services (home-based care) and strengthening networks of providers (IRT Perunderai). Finally, it describes pilot projects to explore new ways to reach MARP.

Section III covers APAC's provision of TA at national, state, and NGO levels—a key component of its program—which became more significant as many activities were transferred to the state in 2010. Methodologies included direct staff placement; the use of consultants; training; and in

Phase III, a new partnership with TANSACS and other SACS to help guide new program management structures such as the TSUs and DAPCUs.

Section IV analyzes approaches to working with the private sector. Underlying principles for successful PPPs are reviewed. The section also includes useful planning tools, including a framework for a partner leveraging equation. Case studies (see Appendix E) include (1) a direct partnership with a manufacturer for CSM; (2) an industry partnership in developing the Hello+ Helpline; and (3) a partnership with the private medical sector (Nakshatra).

Section V provides an overview of APAC's M&E system, focusing on the systems and research agenda that underpin program quality, such as data quality assessments (DQAs), PSVs, ESRMs, and M&E trainings for APAC partners.

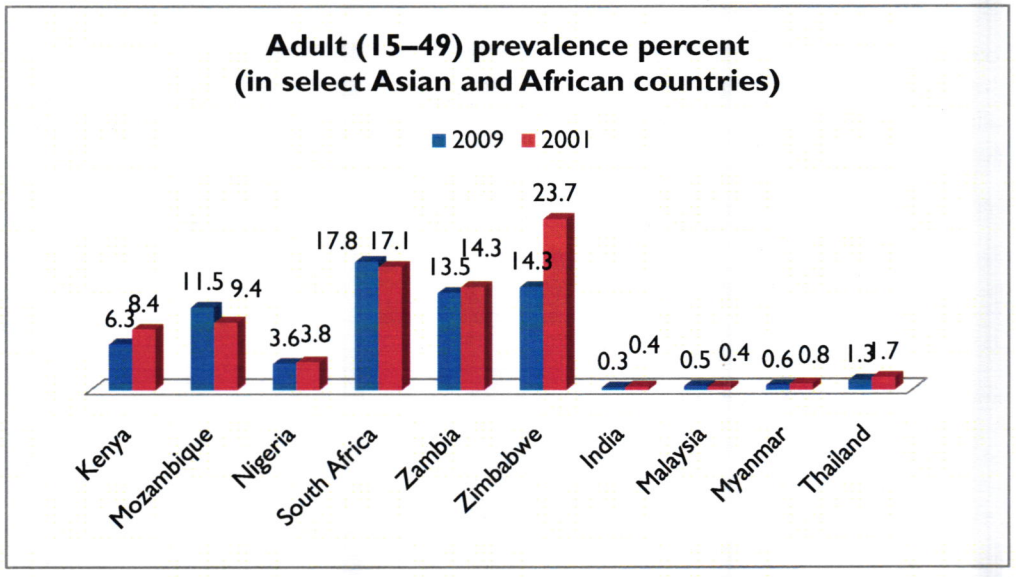
Section VI provides an overview of the process used to transition NGOs to the government.

I. INTRODUCTION

HIV/AIDS IN INDIA

India is the second most populous country in the world and home to the third largest number of people living with HIV/AIDS. However, the estimated adult HIV prevalence in India has declined from 0.45% in 2002 to 0.29% in 2008. The estimated number of people living with HIV/AIDS (PLWHA) has also declined from 2.73 to 2.27 million over the same period. Figure 1 shows the HIV prevalence in selected Asian and African countries.

Figure 1. Prevalence of HIV/AIDS in Selected Asian and African Countries



(Global report: UNAIDS report on the global AIDS epidemic 2010. UNAIDS, 2010.)

The continuous decline of HIV/AIDS prevalence in India, along with improvement in the quality of HIV/AIDS programming, is attributed to the dynamic leadership and timely support provided by the National AIDS Control Organization (NACO). Under the National AIDS Control Program, Phase III (NACP III), NACO has achieved tremendous success in scaling- up and strengthening the HIV/AIDS Prevention and Care Program in the country. Some of the key achievements under NACP III include:[3]

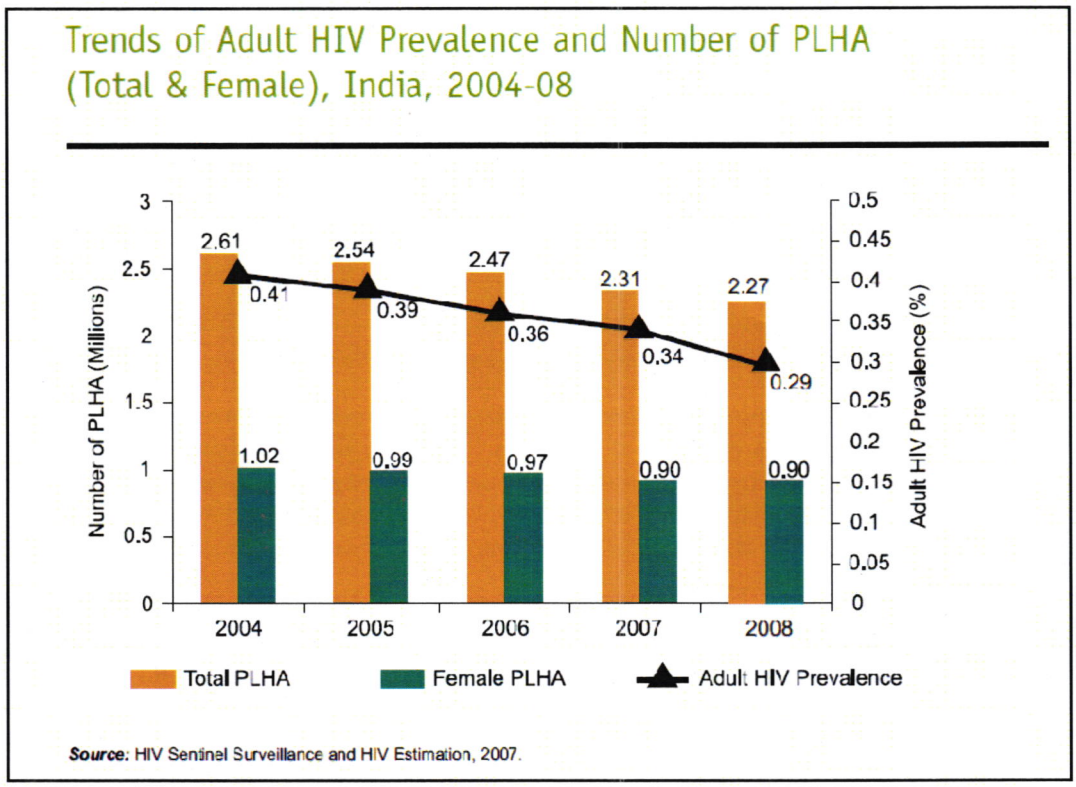
- As of June 2010, 1,311 targeted implementation projects were operational under State AIDS Control Societies (SACS); partners managed an additional 220. These targeted interventions (TIs) cover 78% of the country's 1.26 million female sex workers (FSWs); 73% of 0.18 million intravenous drug users (IDUs); and 77% of 0.35 million males who have sex with males (MSM); and transgender populations.
- The number of integrated counseling and testing centers (ICTCs) increased to 5,210 in June 2010; while the number of persons voluntarily tested was 14.2 million in 2009–2010.

[3] See www.nacoonline.org/.../NACO%20monographs%20for%20Vienna/Final%20NACO%20Monograph%201.pdf. *Accessed on May 27, 2011.*

- During 2009–2010, 8.24 million sexually transmitted infections (STIs) were managed by 938 designated STI/RTI (reproductive tract infection) clinics, STI clinics at the TI sites and more than 26,000 sub-district level health facilities under the National Rural Health Mission (NRHM).
- A total of 322,561 patients were receiving free antiretroviral therapy (ART) as of April 2010. Ten regional centers of excellence provided state-of-the-art services for people living with HIV/AIDS (PLWHA).
- 287 community care centers have been established in NACP-III . Under the National Pediatric HIV/AIDS Initiative, 66,871 children living with HIV have been registered for HIV care at ART centers; 19,613 children received free ART as of January 2010.
- During 2008–2009, annual condom distributed increased to 2.2 billion; 19,700 condom vending machines have been installed across the country.
- Access to safe blood was ensured through a network of 1,103 blood banks, including 132 blood component separation units and 10 model blood banks.

Figure 2 shows the decline in HIV/AIDS between 2004 and 2008. While this decline partly relates to the use of enhanced data, which has provided a more realistic picture, NACO'sscaling-up of HIV/AIDS prevention programs in India has averted thousands of infections during this period.

Figure 2. Trends of Adult HIV Prevalence and Number of PLHA

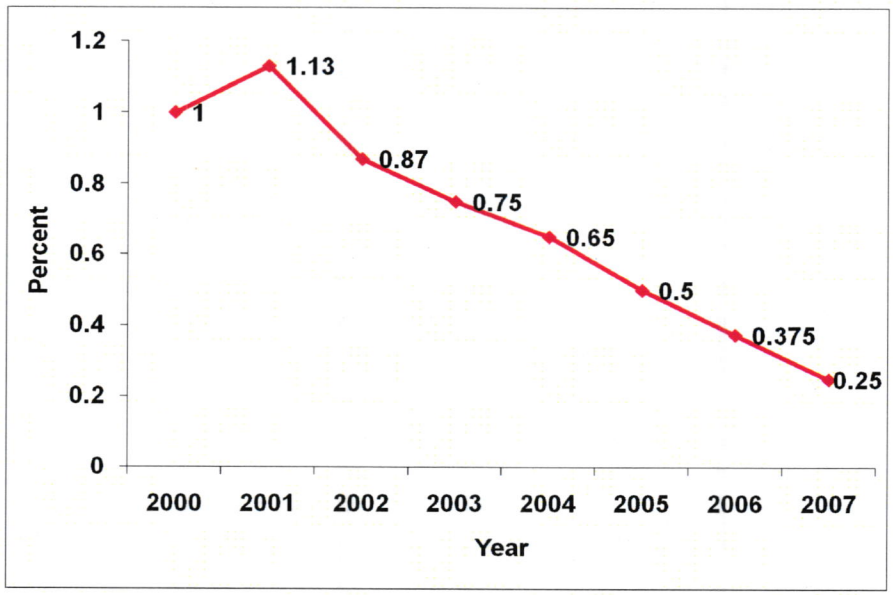


HIV/AIDS IN TAMIL NADU

Tamil Nadu is one of the six high-prevalence states in the country—in 1986, the first HIV case in India was detected in the state. And between 1995 and 1997, HIV prevalence among pregnant

women tripled to around 1.25% (Report on the Global HIV/AIDS Epidemic, 2000). Following this steep increase, the state government acted decisively and the USAID-supported AIDS Prevention and Control Project (APAC) launched its comprehensive HIV/AIDS program. Since 2001, sentinel surveillance data has shown a steady decline among antenatal clinic attendees, as shown in Figure 3.

Figure 3. HIV Prevalence Rate Among Antenatal Clinic Attendees from 2000–2007



In 2007, HIV prevalence among antenatal clinic attendees in Tamil Nadu was 0.25%. The prevalence rate was 16.8% among intravenousdrug users (IDUs), the third highest of all reporting states; 6.6% among men who have sex with men (MSM); and 4.68% among female sex workers (FSWs).[4]

The decline in the prevalence rate in the state was made possible by the concerted efforts of all stakeholders. Strong political will, combined with administrative commitment from the state government, provided a foundation for strong leadership for the HIV Prevention and Care Program, resulting in better implementation of programs in the field. There was a huge scale-up in prevention programs, HIV/AIDS counseling and testing (CT), ART enrollment, and other care and support services over the period. This integrated model of the HIV care continuum, spearheaded by TANSACS, resulted in the convergence of services at all levels.

The state government provided direct funding for such innovations as the Orphans and Vulnerable Children (OVC) Trust and took a leading role in working with development partners to rationalize their programs to avoid duplication. Tamil Nadu has had several development partners supporting HIV/AIDS programs, notably USAID, the Centers for Disease Control and Prevention (CDC); the Bill & Melinda Gates Foundation (BMGF); the Clinton Foundation, UNICEF, and the Children's Investment Fund Foundation, which funded and implemented prevention and care programs to support the states. Civil society organizations (CSOs) and non-governmental organizations (NGOs) also strengthened the SACS and HIV/AIDS programs in the state to ensure that the epidemic was controlled effectively. This scale-up of activities has supported the prevention of new infections and the provision of care and support services for PLWHA closer to their homes.

[4] HIV Sentinel Surveillance and HIV Estimation in India 2007: A Technical Brief.

THE APAC PROJECT

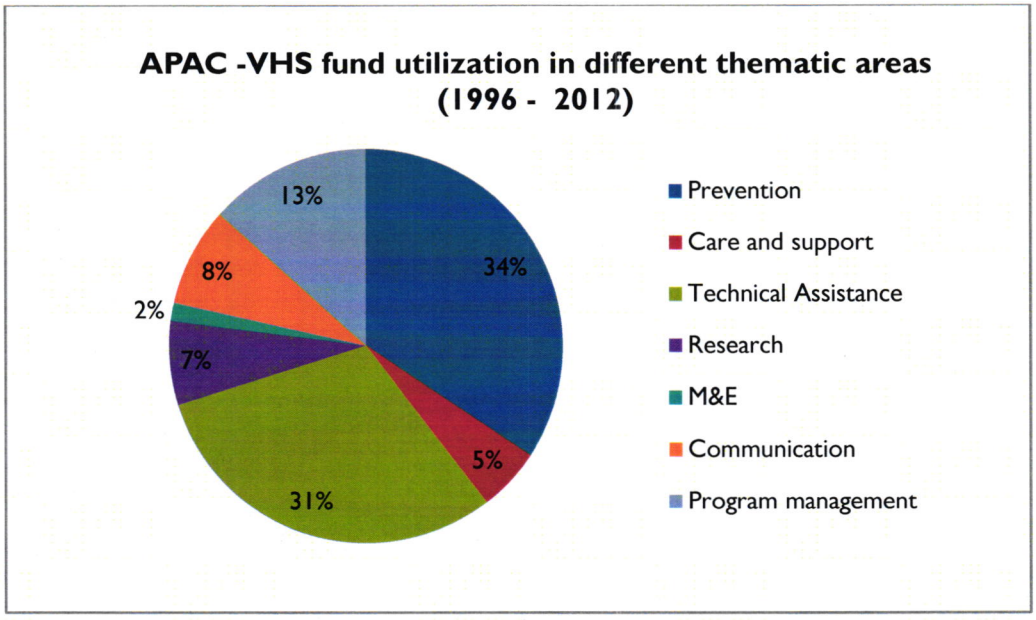
Integral to APAC's achievements was a strong, flexible partnership between the United States Agency for International Development (USAID), the Government of India (GOI), and Voluntary Health Services (VHS), a well-established NGO in Chennai. These three parties signed a tripartite agreement in 1995 that established APAC. With funding from USAID under agreement with the GOI, VHS administered the program. An APAC office within VHS managed the project. VHS, a large and highly regarded NGO in Tamil Nadu, was founded in 1958. It provides medical services targeted to lower-income groups through its hospital and associated clinics. APAC was unique because it was the first major project designed in partnership with the GOI and the Tamil Nadu state government to be implemented through an Indian NGO.

At the time, stigma against HIV/AIDS was high, and there was no comprehensive program to target those most at risk. Little was known about the composition or structure of the sex industry. Prevention activities, led by a few NGOs, mainly focused on increasing awareness. Working in partnership with TANSACS, APAC was the first program in India to scale-up a comprehensive HIV/AIDS prevention program for most-at-risk populations (MARP). In doing so, it provided a model for future state-level interventions, components of which contributed to technical interventions at the national and state levels and leveraged the work of other organizations.

APAC functioned as an umbrella organization, under which services were provided and managed through a mix of NGOs, technical specialist firms, and private consultants. APAC set strategic directions, monitored overall results, and nurtured community ownership and individual skill development. The project's commitment to strengthening both communities and individuals was equally important. NGO partners and APAC staff were continuously supported through participatory systems for training, exchange, and review. This leadership style was one of the major factors that contributed to the long-term impact of the project.

Total funding over the life of the project was $47.25 million. Funds were assigned to program areas, as shown in Figure 4.

Figure 4. APAC/VHS Fund Use in Different Thematic Areas



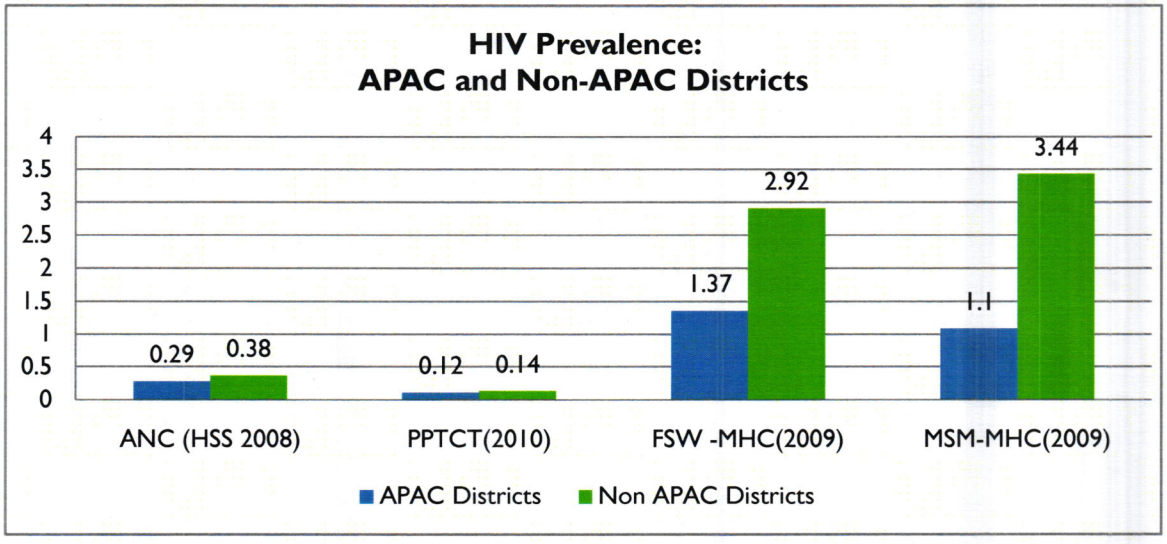
Most of APAC's funds supported prevention and TA programs; a component of the TA budget was staff salaries, who were seconded to the national and state HIV/AIDS program. The relatively small amount spent on care and support reflects the priorities of the triparite agreement: to target high-risk populations to reduce the transmission of HIV/AIDS. It is also notable that there is a separate fund for research, almost equal to the funding set aside for communication—which includes events and campaigns, but not peer education activities.

MAJOR ACHIEVEMENTS OF APAC

The major achievements of the APAC Project over its 17-year history include the following:

- From 1995–2004, APAC was the only comprehensive large-scale program working with TANSACS to implement interventions with MARP in the state. APAC's programs substantially contributed to halting and reversing the epidemic while supporting positive changes in HIV-AIDS-related attitudes and behavior in Tamil Nadu. APAC's success in supporting the reduction of HIV prevalence among general and MARPs in its intervention (seven districts is shown in Figure 5 (source: TANSACS annual report and Tamil Nadu Master Health Check-up records).

Figure 5. HIV Prevalence in APAC and Non-APAC Districts



- The partnership between USAID, VHS, and the GOI (at the national and state levels) serves as a successful model for collaborative program management—one that has fostered innovation and commitment to sustainable HIV/AIDS programming.
- APAC's investment in NGO capacity building and its partnership approach were key factors in successful project implementation. APAC provided NGO staff with training, technical assistance (TA), and regular opportunities to share experiences. APAC also developed varied partnerships with the public and private medical sector, the corporate sector, universities, and government organizations for program implementation.
- The project established a strong participatory culture that fostered individual growth and community mobilization among previously marginalized populations. This was fostered through standardized systems of joint review and exchange, as well as a system that rewarded individual commitment with more responsibility, from peer educators (PE) to leaders of community-based organizations (CBOs).

- APAC pioneered and systematized the concept of working with TIs in Tamil Nadu and facilitated its scale-up. In its third phase, the project worked with approximately 20% of the state's high-risk populations.
- Even in the early years, the program had an immediate and lasting effect on sexual behavior, with increased condom use reported among sex workers (from 56% in 1996 to 88% in 2002) and truckers (from 44% in 1996 to 78.7% in 2002), and an increase in care-seeking behavior among truckers (from 64% in 1996 to 73.7% in 2002).[5]
- APAC established the first condom social marketing (CSM) program in India, which was built on a successful public-private partnership (PPP) between APAC, a condom manufacturer and local NGOs. The program contributed to an increase in the number of condom retail outlets, which nearly doubled, rising (from 17,600 in 1996 to 35,400 in 1999); condom sales more than doubled, rising from 12.6 million annually in 1995 to an estimated 27.9 million in 1999.[6]
- The first Behavioural Surveillance Survey (BSS) in India (in 1996) has become an ongoing tool for tracking behavior change, with 12 waves of BSS completed to date. The project has undertaken more than 50 behavioral, epidemiological, and facility-based research studies, significantly improving the evidence available to program managers and policymakers in the state.
- APAC developed a comprehensive training approach that included support for a network of continuing education and training centers (CETCs), demonstration centers, and resource and training centers (R&TCs). It also supported curriculum development in both technical and program management, with comprehensive training provided to more than 100 NGOs and CBOs during the life of the program.
- The project conceptualized the OVC Trust to provide sustainable support to OVC in Tamil Nadu; it promoted its adoption by TANSACS and the approval of a fund of 5 crores ($1.25 million) to support the trust. This assisted nearly 20% of OVC (OVC Assessment Report, 2011), who benefitted from educational, nutritional, economic, and medical programs.
- APAC developed a data quality assurance (DQA) system that has improved performance and resource management through integration in the management information system (MIS) of all NGO partners.
- The project successfully transitioned many projects to state management, ensuring sustainable HIV/AIDS programming.
- APAC provided TA at the national and state levels in planning and operational approaches for TIs; effective communication; decentralized program management; and health system strengthening. Significant TA has been provided to TANSACS through the strategic information management unit, technical support unit, DAPCU, and expert advice for technical reviews.
- Gaining experience in project and data management has benefited the state beyond the field of HIV/AIDS through strengthened health systems. In Phase III, APAC worked closely with the Tamil Nadu Health Systems Project, addressing biomedical waste and infection control, supporting research in those areas; strengthening the state's Web-based HMIS system; and setting up a State Health Data Resource Center.

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[5]See the AIDS Prevention and Control Report, March 2006.

[6] See the APAC Mid-term Evaluation, May 2000, which also reports on the Operations Research Group Retail Audit Report, 1999.

- In partnership with the TNHSP, it organized the first international conference on health system strengthening in India, which resulted in several assessments and studies related to health system strengthening and facilitation of data and communication sharing in the state. APAC assessments and technical support have helped the state mobilize additional resources of $120 million.
- The project has implemented innovative behavior change communication (BCC) programs that have positioned the project to play a lead role in communication in the state and support national HIV/AIDS communication efforts. They include target audience-specific IEC materials; a systematic approach to undertaking communication programs based on needs assessment; pre-testing and evaluation of communication campaigns; and development of a comprehensive state-level communication strategy.

II. PROJECT MANAGEMENT AND GOVERNANCE

INTRODUCTION

Project management and governance are critical to the success of any organization; this is no less true for the APAC Project. APAC was established under an innovative partnership between the GOI, VHS, and USAID. This partnership focused from the start on the establishment of effective project management and transparent governance systems.

GUIDING PRINCIPLES

Key to APAC's success was the establishment of guiding principles that (1) helped ensure successful outcomes; (2) focused on mutual respect; and (3) developed strong partnerships and effective systems. Other important elements of success included the following:

- A tripartite agreement that clearly assigned roles and responsibilities;
- Selection of an Indian implementing partner—VHS;
- Strong partnership with the government and donor;
- Investment in partnership-building;
- Strong community focus;
- Dynamic leadership at APAC;
- Human resource development;
- Empowering management principles, which fostered staff innovation;
- Strong program management and financial systems; and
- Sound governance structures and systems.

KEY FACTORS FOR SUCCESS

Tripartite Agreement

The APAC Project was launched in 1995 following the signing of a tripartite agreement between USAID, the GOI's NACO and VHS (the implementing organization of Chennai, Tamil Nadu). This partnership contributed to a unique project management model that fostered equal responsibility, clearly defined roles and responsibilities, and a governance system.

USAID supported APAC through all three phases of the project. During Phase II, APAC (in dialogue with NACO, TANSACS and USAID) identified additional priorities to address, including innovations in prevention, care, support, and treatment; as well as research and communication. In response, USAID introduced a technical assistance component (TAC) in 2005, using unilateral funding to VHS to implement the agreed activities. This flexible approach, supported by the government, helped the project innovate and take risks—such as testing new models for prevention and care, and broadening the project's scope to support new work in new areas—such as health systems strengthening.

Selection of an Indian NGO (VHS)

Selecting an Indian implementing partner and organization, such as VHS, rather than working through an international non-governmental organization (INGO) was a critical factor in the APAC Project's success. When the project was first designed in 1992, USAID/India had the foresight to recognize the role that an Indian NGO could play. Well-respected, VHS had already

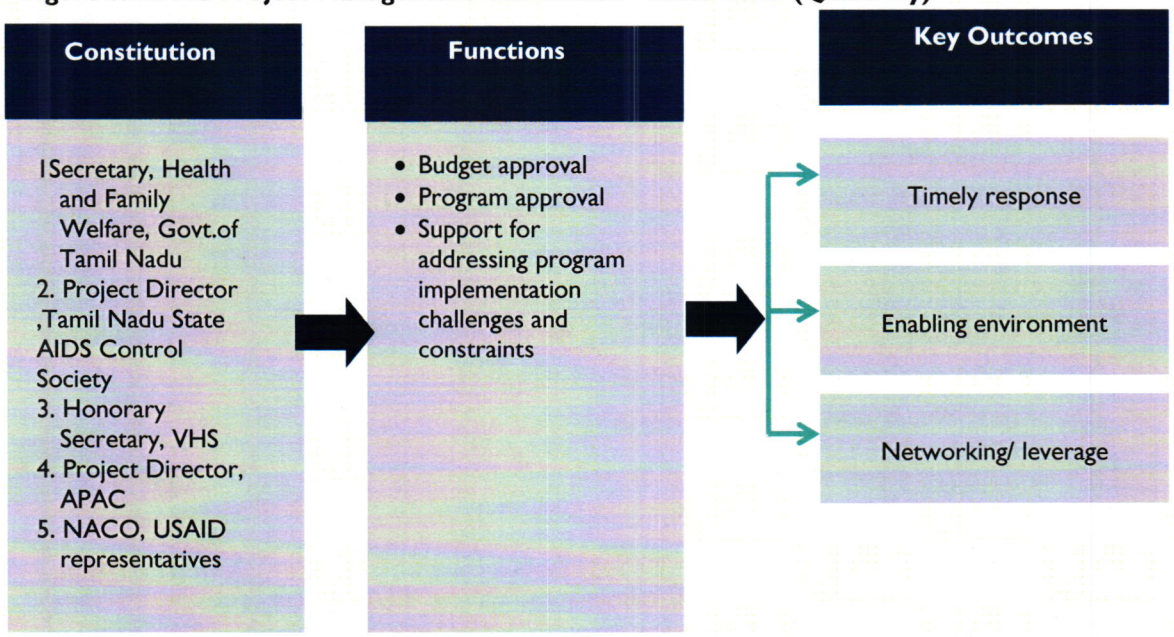
built an impressive track record with more than 35 years of providing preventive health services to marginalized populations at the state level; it also had strong governance and management systems.

Prior to awarding the grant to VHS, USAID and GOI conducted an organizational assessment, which deemed the NGO appropriate for the award. VHS became accountable for project management and governance as well as for fostering partnerships with government and CSOs at the state level. Selecting VHS as a prime partner facilitated confidence among NGOs and supported the building of NGO-GOI partnerships in HIV/AIDS programs. A vast majority of VHS sub-grantees are also local institutions—highlighting the project's emphasis on building local capacity and sustainable solutions.

Innovative Project Management Mechanisms

The innovative mechanisms for project management created a structure that facilitated the ongoing involvement of all three parties in the program.

Figure 6. APAC Project Management Committee—State Level (Quarterly)



As shown in Figure 6, project activities were guided by the Project Management Committee (PMC), chaired by the state health secretary, with the project director of TANSACS as co-chair and the project director of APAC as member secretary. VHS, NACO, and USAID are permanent members of the PMC and an integral part of the structure. The PMC meets quarterly to review and approve: the annual action plan, ongoing activities and results, new expenditures, and new project and research proposals. It also provided a platform for discussing synergies, address duplication of efforts, and how best to leverage additional resources for the project in support of the state's initiatives. PMC's inclusive nature promoted quick decision-making, which enabled APAC to roll out the program in a timely manner. This was supported by a process for providing approval in the event of an emergency through a circulation note signed by all members. The consistency of PMC meetings was a strong factor in promoting joint leadership: over 80% of PMC meetings were held as planned.

The involvement of key policymakers at the state and national levels with VHS, the project staff, and the donor facilitated state accountability and oversight. It also supported an environment conducive to developing and implementing community-based programs to help reduce the prevalence of HIV/AIDS in the state and to mainstream HIV/AIDS prevention, care, and treatment. It also facilitated APAC's later move to focus on other diseases and to help strengthen the state's overall health system.

Achievements:

- APAC and TNSACS established a strong partnership with good coordination.
- Resources (i.e., condoms, STI drugs) were leveraged to address policy-level gaps.
- Complementary partners eliminated duplication and optimized resource use.
- Establishment of a platform for disseminating APAC best practices, evidence, and lessons learned from pilot initiatives led to scale-up, policy decisions, and replication.
- Systematic follow-up on decisions allowed for readdressing issues when needed.
- APAC received critical support from the Health Secretary, who issued government orders, provided direction to SACS and health departments, and ensured that letters were sent to NACO.
- Effective leadership and decision-making ensured rapid program rollout.
- Program established a platform for providing TA for advocacy and networking.

APAC Review Committee—APAC-VHS (Monthly)

The APAC Review Committee (ARC) was an internal body, chaired by the VHS Honorary Secretary and attended by all senior staff, that met monthly or as required. The committee reviewed and approved both planned and ongoing activities—and was authorized to approve all activities with a value less than USD $6,500. The meeting created a single platform for better coordination between the programmatic and financial aspects of the project, which enabled quick transparent decision-making. It also:

- Offered a platform for technical officers to exchange information and learn from one another.
- Facilitated coordination and communication among technical and financial teams on programmatic issues and implementation.
- Allowed for speedy implementation through one mechanism.
- Created a transparent process where all approval authorities (PD APAC, Director–Finance, Secretary VHS) make participatory and joint decisions in the presence of officers.

Working with Government

APAC's design also ensured program ownership by the government. From the start, APAC worked closely with the government, sharing its findings, experience, and expertise through different means. It developed annual plans in close collaboration with SACS, which decreased duplicate work and ensured synergy of efforts. APAC also worked closely with NACO, through participation in NACO working groups; submission of data through the SACS to NACO; and NACO's participation in the APAC PMC.

USAID

From the project's inception in 1992, USAID worked collaboratively with APAC, the state and national governments, and CSOs to conceptualize and facilitate HIV/AIDS prevention activities. In the first years of the project, USAID was active in planning and strategy development, in engagement with key stakeholders, in systems development, in the PMC, and in the selection process for senior staff. USAID also played a consistent role in building consensus and a unified focus among partners and in supporting strong linkages with the public and private sectors.

Later, USAID worked closely with APAC to expand its role beyond HIV/AIDS prevention. During Phase II, the latter focused on moving from an intervention model toward a TA model in Phases II and III, with an increased focus on health system strengthening and planning for the final transition of the project in March 2012.

Investment in Partnership Building

APAC has understood that cultivating partnerships requires time and different approaches depending on the target partner. APAC was flexible while developing partnerships with government, investing time as well as human and financial resources in this process, thereby making a significant contribution to strengthening HIV/AIDS programming in the country. To strengthen networks, APAC supported (1) workshops and conferences to promote mutual learning in communities; (2) annual partner and cluster meetings to facilitate knowledge exchange among its partner organizations; (3) partnerships with several academic and research institutions to foster their capacity and curriculum to meet the needs of the development sector; and (4) partnerships with the private sector to build mutual trust and develop appropriate governance models.

Strong Community Focus

A cornerstone of APAC's success was its strong and innovative partnerships with CSOs/NGOs. APAC's approach combined clear expectations for CSO performance with a strong participatory and inclusive management style. Further, a rigorous process was followed for NGO selection. NGOs were required to have a base in the district, be registered for three years, with a turnover of a minimum of 3 lakhs (USD $300,000) per annum, and have no negative reports. There were also clear expectations for CSO/NGO performance, along with a regular system of monthly reviews to ensure that targets and expenditures were on track.

APAC implemented a participatory, inclusive management style, and, as the project expanded, it encouraged NGOs to follow its own model and act as umbrella organizations with sub-contracts with smaller organizations. NGOs were encouraged to innovate; to propose project and study approaches; and to build strong links with community leaders and the district *panchayat*. This partnership model, based on the philosophy that the community can best define its own needs, was implemented through systems of training, exchange meetings, joint reviews, and interpersonal communication (IPC) between APAC and NGO staff, backed up by APAC support for interactions with community leaders. The focus on community was not new; APAC's innovation was to establish and develop a system that promoted partnership.

Dynamic Leadership

> "The leadership in APAC has contributed to strong coordination with TANSACS and transferred many systems to the state government (TANSACS) and timely expansion beyond HIV/AIDS."
>
> —Dr. Vijay Kumar,IAS, Former PD, TANSACS and TNHSP

Key to APAC's success was selecting a dynamic project director (PD) who engaged with and supported the government, CSOs, and donors as equal partners in project planning, management, implementation, and monitoring. The PDs also demonstrated flexibility, provided strategic direction, diversified funding, and remained

accountable and transparent. Since 1995, the PDs have demonstrated many of these qualities, which has fostered partnerships, ownership, and respect throughout the 17 years of the project.

Human Resource Development

As noted above, APAC values human resource development (HRD) and is committed to building the capacity of its staff as emergent leaders in the state. Staff are provided the freedom and space needed to innovate and take calculated risks, which has enabled them to perform at a high level. APAC has a small core team of professionals (8, 12, and 16 in Phases I, II, and III, respectively) who are technically competent and share a passion for helping vulnerable populations increase their access to quality, gender-sensitive HIV/AIDS/STI services.

The staff structure is complemented by a network of technical consultants, which enables APAC to respond to the needs of its partners, carry out parallel activities, and ensure timely rollout of a cost-effective program with effective monitoring. The consultants, who are experts in public health, social science research, strategic planning, communication, and other fields, are committed to working on HIV/AIDS and STI issues. APAC utilizes a systematic approach to identifying consultants; building and maintaining their capacity; and thereafter including them in APAC over the long term. This ensures standardization and consistency, and enables APAC to be responsive and efficient in providing TA to the government, NGOs, and the private sector. (Consultants assist with specific technical issues, while management consulting firms developed the human resources manual, communications, IEC, etc.)

To build capacity, APAC staff are mentored, provided on-site training, and invited to participate in joint planning, monitoring, and experience-sharing visits to the field. Staff and consultants are treated as an integral part of the team. Staff also participate in higher-level training at the state, national, and international levels. Since Phase I, annual plans have included budget allocation for staff development.

Project staff participate in field visits across both districts and states, accompanied by a senior staff member or consultant. Staff are provided with briefing materials prior to participating in visits and, at the end of each day, meet to reflect on learning.

Empowering Management Principles

APAC management has empowered its staff to innovate and take risks. Staff are encouraged to share new ideas with seniors and colleagues, who provide insightful feedback. Staff members have been able to develop enterprising ideas into pilot initiatives and test them for impact and sustainability. As a result, several new initiatives have been designed and implemented.

Strong Program Management and Financial Systems

Strong program management and financial systems have ensured that programs and finances are always on track. Examples include: the ARC regularly monitored APAC's program implementation. It analyzed and provided feedback on NGO monthly reports and financial reports. Staff and consultants made regular field visits to assess progress and provide technical support. NGOs submit financial reports on a monthly basis, removing the scope for any manipulation at a later stage. Transparent procurement and financial systems ensured the competitiveness of the rates of goods procured and the proper implementation of financial guidelines.

Governance

An integral component of the project, governance was built into the VHS and APAC management structures (PMC and ARC); into staffing (selecting, hiring, and promoting); and into systems such as its annual International Standardization Organization (ISO) certification, quality

data audits, and statutory audits. And, from its start, APAC developed and operationalized stringent criteria for NGO selection (detailed earlier in this report). NGOs were required to have a base in the district, be registered for three years, with a turnover of a minimum of 3 lakhs (USD $300,000) per annum, and have no negative reports.

Utilizing a rigorous, systematic, and transparent process for selecting NGOs (through invitation for applications), NGOs were selected and awarded grants in thematic areas over the life of the project. The grant-making component of the project and APAC's ability to rapidly respond to the needs of the community and its partners provided value added; and it enabled the project to rapidly disburse smaller grants to NGOs and CBOs involved in HRG interventions and with vulnerable populations such as PLWHA.

A direct impact of the grant-making mechanism has been the development of PLWHA networks in Tamil Nadu, Kerela, and Puducherry. Through these networks, PLWHA have been able to articulate specific concerns—such as stigma, discrimination, and issues of access to integrated counseling and testing center (ICTC) services at government hospitals—and then mobilize to take action. For example, in Kanyakumari district, PLWHA worked with APAC and DAPCU officials to create an enabling environment at the government ICTC centers supporting the provision of timely, quality services.

NACO has adopted APAC's NGO selection criteria as well as its grant-making system, which has helped in program accountability, legal compliance, and transparency.

KEY OBSERVATIONS

- A collaborative partnership that included the government at state, local, and national levels was critical in leveraging additional resources.
- Consistent meetings of the PMC, the project's chief management body, were a key factor in the project's success—the meetings ensured that key stakeholders (GOI, USAID, VHS) were jointly responsible for decision-making.
- Establishment of transparent and robust systems for planning, management, and monitoring and evaluation (M&E) have been important for effective grant management. The government adopted these systems at state and national levels.
- Collaboration between USAID staff and APAC ensured strong management and reporting systems for accountability and transparency.
- NGO selection criteria must be developed early to ensure that selected NGOs have the robust systems needed to manage diversified and increased levels of funding.
- APAC's reputation for high quality has meant that local NGOs that received funding were also recognized as accountable and transparent.
- Coordination and synergy between the project and financial offices was essential to timely rollout, efficient management and effective utilization of funds.

III. PREVENTION AND CARE MODELS

In India, HIV/AIDS is a concentrated epidemic, with the sex industry acting as the primary source for spreading the disease. When the APAC program started under the triparite agreement in 1995, little was known about the drivers of the epidemic at both state and national levels. Though there were visible pockets with a significant number of HIV-positive cases, there was no concrete evidence as to why they existed. At the time, the state's urgent concern was to contain the epidemic and prevent its spread to the general population in Tamil Nadu.

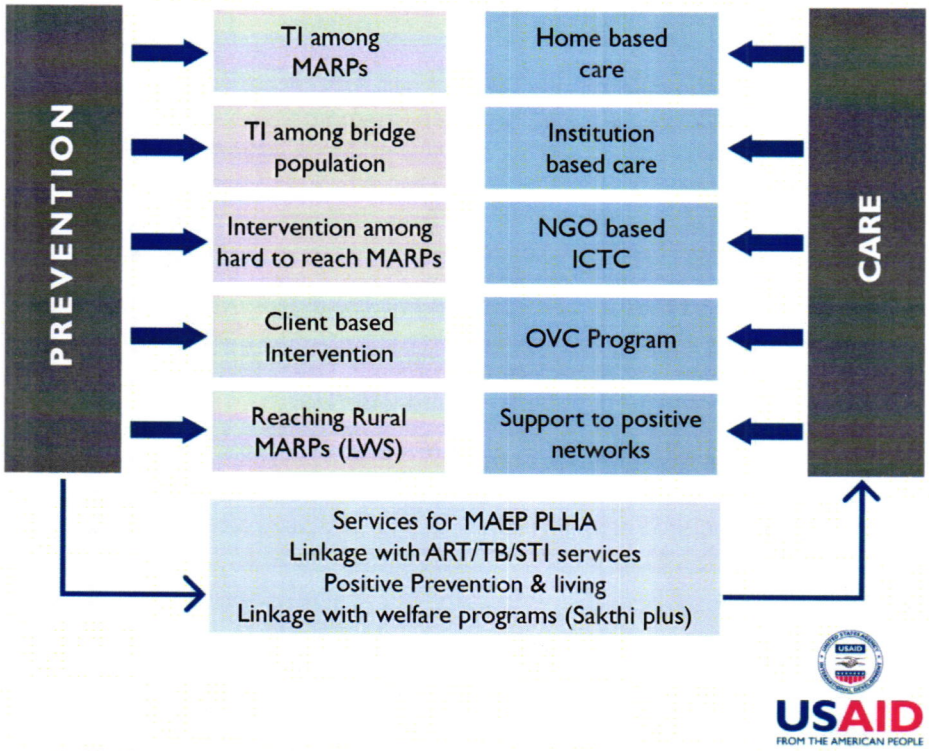
At the time, the focus of the state's HIV/AIDS program was on creating awareness among the general population, without any mechanism for evaluating its impact. APAC conducted its first BSS in 1996 to understand the nature and drivers of the epidemic. Study findings also showed the need for an increased focus on MARP.

Stigma toward HIV/AIDS was high in 1995, both among the general public and among health providers, which resulted in a hidden epidemic that had not yet been fully recognized by state and local leadership. There was limited knowledge about sexual behavior, a topic not openly discussed. The few NGOs that carried out HIV/AIDS interventions, focused on creating awareness through rallies and one-time events. Treatment was not yet available, while counseling and testing was limited. Thus, APAC's emphasis was on prevention. Its primary strategy was to focus its programs on FSWs, a high-risk population with great potential for transmitting the virus. The most effective approach was to target FSWs—and later, other high-risk populations—through a comprehensive prevention program that addressed behavior change through partner reduction and consistent condom use, combined with reduction of STIs through high-quality diagnosis and treatment.

Little was known, however, about the composition or structure of the sex industry. Over the next 17 years, APAC utilized research to build a body of knowledge about the industry that was used to plan and implement programs for FSWs in the most high-risk communities in the state. The program was embedded in the FSW and other target communities and continuously revised based on their needs and the changing situation. Later, APAC began to target other high-risk populations.

The model in Figure 7 sets out the key elements of APAC's Prevention and Care Program to reach MARP.

Figure 7. Prevention and Care Models



Delete USAID logo, Spelling mistakes (MAEP should be MARP, check spellings)

APAC's model for prevention and care interventions for MARP was the first comprehensive state-wide program that focused on extending intensive, targeted programs to meet their prevention and care needs. Its success is reflected in the reduction of HIV prevalence in the state of Tamil Nadu. APAC's program provides a model for other states. Components of the program have contributed to interventions at national and state levels and informed the work of other organizations.

The following section outlines APAC's key models in prevention and care. It reviews the components of the initial TI model for prevention among FSWs, MSMs and briefly describes prevention programs for other populations: truckers, and industrial and slum populations. Recent approaches to designing and supporting new models for reaching MARP are included. The subsection on care and support highlights interventions to build capacity in the private medical sector, work in home-based care, develop the OVC Trust, and support alternative livelihoods for FSWs.

GUIDING PRINCIPLES FOR APAC'S PREVENTION PROGRAMS

APAC's TIs focused on:

- Evidence-based programs
- Community engagement and ownership
- Comprehensive package of services
- Strong emphasis on building capacity and project monitoring
- Continuous innovations

ACHIEVEMENTS IN PREVENTION

- APAC developed the first scaled-up approach to identify and work with MARP to reduce their risk of HIV infection. This approach is widely seen as having contributed to the decrease in HIV prevalence in Tamil Nadu. The TI program has been recognized as a national model: APAC chaired the Technical Resource Group on Targeted Interventions in NACP II and acted as vice-chair in NACP III. During Phases I and II, the project established three demonstration centers and trained NGO and SACS officials across the country.
- APAC introduced India's first holistic condom social marketing program within HIV/AIDS programs, which contributed to increased condom use among MARP, overall condom market growth, and normalization of condom use.
- APAC's focus on community, participation, stigma reduction, and involvement of MARP in program design and implementation helped shift public perceptions regarding these communities.
- APAC's umbrella model and management systems for scaling up helped build partner capacity and to bolster the self-esteem and capabilities of target communities. This participatory management approach was effective because it was continuously reinforced. Funding and time were dedicated to joint reviews, feedback, support for forming associations, and experience-sharing meetings.
- Comprehensive training was provided to more than 100 NGOs and CBOs, health care providers (HCP), peer educators (Es), and others active in a wide range of technical and management areas.
- APAC was flexible and deftly responded to changes in policy and coverage by the government and donor. For example, in Phase II, APAC expanded its program to include NGO programs for care and support for PLWHA; these programs were later transitioned when government services expanded under NACP III.
- APAC cultivated NGO staff skills by identifying certain organizations to function as District Resource and Training Centres (DRTCs) focused on specific expertise (folk media, MARP, OVC support).
- APAC's knowledge-based programs resulted in pilot projects to respond to new social and epidemiological developments—for example, the shift of the epidemic to rural areas and changes in the sex-work industry.
- APAC was awarded an ISO certification in 2010 for four areas of its work, including TIs and its role in the Link Worker (LW) scheme (see the subsection below on reaching rural MARP and the LW scheme).

PIONEERING TARGETED INTERVENTIONS IN TAMIL NADU

APAC pioneered the comprehensive intervention methodologies used to reach the MARP and later adapted them for other high-risk and vulnerable populations in Tamil Nadu though interventions managed through APAC's NGO partners. In Phase I, APAC supported 27 interventions for MARP and bridge and vulnerable populations (the latter including communities along the highways and slum populations); the TIs reached over 200,000 people (9,750 of which were in programs for FSWs/tourists). In Phase II, 58 interventions reached over 480,000 persons, of which more than 21,000 were FSWs/tourists or MSM. In Phase III, the program

worked through 49 interventions to reach over 300,000 people, including over 40,000 FSWs, MSM, and IDUs.[7] Table 1 highlights these numbers.

Table 1. Populations Targeted under APAC

Population Targeted	Phase I (1997–2002)	Phase II (2002–2007)	Phase III (2007–2012)
Most at-risk-populations (FSWs, MSMs, IDUs)	9750	21,058	41,139
Bridge populations (prevention along the highway: truckers, migrants)	169,100	195,000	118,423
General population (slum communities, workplace programs)	23,760	144,800	

Programs were delivered through selected NGOs, which managed comprehensive interventions delivered through a combination of staff; partnerships with condom retailers and manufacturers; linkages and partnerships with public and private HCPs; and voluntary PEs from the community.

EVIDENCE-BASED PROGRAMMING

A strong evidence base informed program design. India's first BSS study (1996) informed the interventions with FSWs (see the SI section for additional information on the BSS). Other innovative studies included a research study that established the current status of condom availability, accessibility, and quality (1996); and two studies that assessed the prevalence of STIs in Tamil Nadu among high-risk communities (1999) and the general population (2003).

Another innovation was the use of mapping to determine the structure of the sex-work industry. Information garnered included locations for sex work (brothel, street or home); locations of FSW groups; and details about secondary target groups connected with the industry. This information allowed APAC to work with partner NGOs to better tailor programs for the industry. The same approach was used in the MSM program to identify subgroups of MSM and their preferred locations and meeting places. This use of evidence-based programming continued to underpin all APAC's models for prevention and care.

COMPREHENSIVE PACKAGE OF SERVICES

Condom Social Marketing

APAC introduced a CSM program for HIV interventions in India—and pioneered collaborative partnerships with the private sector to increase access to condoms for the MARP and clients. The core of this program was a PPP that linked APAC, local NGOs, and condom manufacturers in a joint initiative. (See the subsection on the private sector.) On the supply side, APAC NGOs identified, motivated, and trained unconventional outlet retailers in intervention areas, and linked them with a partner condom manufacturer. APAC also leveraged subsidized condoms from TANSACS to distribute among MARP at no cost. The project supported campaigns to create demand for condoms and also conducted the first condom quality at point-of-purchase study (prior to this, studies were conducted at point-of-manufacture), which resulted in condom manufacturers improving the quality of condoms. Similarly, a condom use-to-waste study helped assesses waste at different levels in the free distribution of condoms and then addressed gaps. The project also pioneered the training of NGOs on CSM and retail outlets that did not stock

[7] Taken from APAC records of numbers reached. Individuals may be duplicated in different phases, so the numbers in each phase cannot be added together.

condoms. As a result, NGOs took an active role in CSM and increased access. In addition, outreach workers (OW) and PEs identified situations where condom use was compromised and encouraged MARP in consistent condom use through negotiation techniques.

Sustainable, long-term impact includes the initial acceptance of condom use, increased use of condoms by MARP, and increased distribution of condoms in small retail outlets. TANSACS later adopted this methodology and provided a revolving fund for NGOs to ensure a constant supply to outlets through social marketing.

Access to STI Treatment

APAC addressed the need for increased access to STI treatment and, later, CT, by referring HIV-positive and at-risk populations to public and private facilities. APAC developed sound systems for referring and tracking the use of health services by MARP, and for providing ongoing training for NGOs and HCPs to strengthen quality.

The BSS showed that more than 57% of STI patients consulted private HCPs, including a sizeable number of unqualified, non-allopathic practitioners. APAC's early programs provided training in STI management on an intermittent basis in response to identified need. In 2000, APAC identified five institutions as potential continuing education and training centers (CETC), and funded training on STI management for a wide range of HCPs (doctors, indigenous practitioners, nurse midwives, and community health workers [CHW]). Doctors were trained on syndromic case management and counseling; others were trained on the importance of proper treatment, counseling, and referral. The project had a multi-pronged strategy for increasing access to STI treatment services, including (1) support for a network of community-preferred private providers; (2) support for NGO-managed STI clinics; and (3) a strong referral and follow-up system for MARP who preferred care from government STI clinics. Further, innovative and bold media campaigns increased the demand for STI services. The project also used TA to support assessments of, and community preference for, government STI clinics in Tamil Nadu. These resulted in substantively improving the quality of STI services in government facilities.

Behavior Change Communication

Behavior change communication for MARP focused on two goals: to build the skills and confidence needed for MARP to protect themselves from HIV/AIDS, and to create demand for HIV/AIDS services. The BCC was integral to the support of advocacy programs that reduced stigma and discrimination against both MARP and PLWHA and their families. The project used multiple approaches to reach and change the behaviors of MARP, as well as to impact the level of knowledge and attitudes of the general population.

Behavior Change Communication Focused on:

- Interpersonal communication (IPC) to promote behavior change;
- A peer-led approach, which promoted voluntary PEs for effective outreach (see subsection on community mobilization);
- Evidence-based mass media campaigns;
- Creating an HIV/AIDS helpline (see subsection on the private sector) and promoting the use of IT-enabled communication, such as using SMS messages to reach FSWs;
- Various BCC events such as street plays, exhibitions, audio/video shows, and district-level communication campaigns to identify hidden populations, create demand for services, promote general awareness, and counter myths and misconceptions; and
- Development and distribution of audience-specific IEC, including display materials and communication aids.

HIV/AIDS messages focused on prevention, accurate knowledge, skilled negotiation with FSW clients, condom use, and access to STI and HIV testing services. Interpersonal messages were reinforced with specific materials developed for MARP communities with their input. The quality of IPC was supervised and closely monitored by the program's outreach workers, through monthly program reviews and a training program for PEs.

Community Engagement and Ownership

APAC's investment in capacity building for MARP helped to increase their confidence and self esteem, come together as a more cohesive group, and work together to improve their welfare and well-being. This approach was closely linked to peer education as the main avenue for IPC to support MARP in behavior change. The use of volunteer PEs was a basic principle for APAC as well as a pragmatic operational choice. It provided a means to support individual commitment, motivate a large number of community members, and mobilize the community. Peer educators were mentored and supervised to ensure they performed effectively.

VOLUNTARY PEER EDUCATION

The Volunteer Concept

A key component of APAC's approach to reaching MARP was the use of volunteer PEs. NGO staff identified PEs within the target community at intervention sites and then mentored them in their roles. Peer educators were more accepted by communities; they were willing to dedicate time and get involved in the respective trades; and they had communication skills that supported positive behavior change.

The system of using PEs took a comprehensive approach and included (1) selecting PEs; (2) training and building capacity in knowledge of HIV/AIDS; (3) developing skills; (4) mentoring; (5) motivating; (6) graduating PEs; and (7) starting the process again at regular intervals with new PEs. This model differed from other models in the country, which offered financial compensation on a regular basis. This voluntary approach resulted in more acceptability, timely interventions that addressed issues in the field, societal recognition, and joint crisis management.

PE Responsibilities

Based on experience, APAC developed a ratio of 1 PE to 30 community members. The PEs played a crucial role in disseminating information on HIV/AIDS; educating HRGs on safer sex,

condom use, and condom negotiation; distributing condoms; and referring those with STIs for treatment. They also increased demand for CT and helped to refer HIV-positive persons to treatment and care services. PEs carried out IPC activities by using a target specific resource kit. They also supported ORWs in BCC events such as street plays, exhibitions and videos/shows.

Training

A six-module basic training was developed through a consultative process with community members and was later expanded to include refresher training in care. In 2000, APAC revised and standardized the curriculum. APAC identified an NGO to provide a trainer of trainers (TOT) program for peer education—training the NGO staff that then trained PEs. The TOT system promoted quality messages despite the high turnover of PEs.

Capacity Building and Motivation

To sustain PE involvement and motivation, APAC provided volunteers with exposure visits to other interventions and states; the PE convention; experience sharing; awards for best PEs; case studies/success stories; PE network newsletters; and selection of office bearers and advisory committee members from the network. This was a continuous process: APAC continued to select and train PEs to address attrition and maintain an optimum ratio in intervention locations. APAC maintained its relationships with all trained PEs and invited them for district- and state-level conventions.

Supervision and Monitoring

The implementing NGO supervised and monitored the work of PEs. It also made regular field visits and submitted monthly technical review reports to APAC. There were weekly and monthly review meetings with PEs and staff; APAC staff and the NGO also conducted participatory site visits every six months. Exposure visits and ESRM allowed NGOs to interact and build technical expertise and self-esteem.

Outcomes and Transition

The voluntary PE system reached the unreached; supported sustainable behavior change among community members; increased referrals for service uptake; led to a community mobilization process for forming CBOs in each site; and paved the way for the NGO/CBO transition process. Several PE associations that formed under the program have continued to operate after transitioning from APAC. This system was a building block for greater community awareness and mobilization.

Over the life of the project APAC recruited, trained, motivated and used the services of more than 16,000 PEs.

This system—training PEs and forming PE networks and associations at cluster, district and state levels, as highlighted in Figure 8—nurtured leadership qualities, enabling some individuals and associations to pursue new roles after the project closed. Activities such as the development and publication of a newsletter by the Peer Educators Association, with pertinent messages from PEs, helped to build individual confidence.

APAC's systems for training and mentoring PEs also facilitated community mobilization through: joint review visits to the project; inclusion of PEs in discussions on project design and research approaches; and exchange of ideas and experiences between PE leaders at association meetings and the annual ESRM. Starting in Phase II, APAC promoted the formation of CBOs, which was propelled forward through APAC's interventions with MSM. Several MSM groups were already registered as CBOs and entered into agreements with APAC NGOs. To strengthen these CBOs, APAC developed a resource kit to train them in good governance; supported exposure

visits; mentored them; and offered overall support. In Phase III, a new structure allowed individual community members to take on increasing responsibility and progress toward CBO leadership.

Figure 8. Empowerment through Peer Education

- Financial Support to CBO for Intervention (ACE, SWAM, Sahodaran, TDPS)
- Promotion of well performing PE networks as CBO (ACE, Natchathra, IFPEC)
- Promotion of well performing PE as out reach workers (ORW)
- Mentoring and monitoring by ORW
- Motivation, building capacity and recruitment of PEs
- Identification of persons who had undergone behavior change

Key Achievements in Community Mobilization

- Continuation of project activities under other organizations after official transition from APAC.
- Sustainable behavior change—positive peer pressure to practice safe sex and utilize services.
- Increased solidarity among the FSW and MSM communities.
- An ongoing community crisis response system in all districts, empowering the community to address issues of harassment.
- Capable CBOs, which are available to conduct interventions and ready for NGO-CBO transition.

REACHING FEMALE SEX WORKERS

In India, the primary driver of the HIV/AIDS epidemic is unprotected sex work. Female sex workers face stigma; gender and social inequalities; and have poor access to HIV care, support, and treatment services. As noted earlier, APAC first targeted FSWs to make the greatest impact in preventing the spread of HIV/AIDS. Mapping reports indicated that there were different categories of sex work and the project adopted different approaches to reach these groups with prevention and care programs. These include tourist interventions; creating meeting places for FSWs; and encouraging a climate of openness and trust through the voluntary PE system. The core methodology to reach FSWs focused on volunteer PEs from the sex worker community who acted as the primary channel for IEC; this was supported by increased access to condoms and referrals for STI services. Training, monitoring, and exchange systems were developed to strengthen the knowledge and commitment of FSWs. Studies also identified secondary target groups connected with the industry— drivers, pimps, madams, and brokers—and NGOs developed programs for these communities, backed by advocacy with community leaders and legal support. Street events were a means to attract and identify other, hidden women at risk. APAC worked with its partner NGOs to design programs tailored for specific audiences and characteristics of sex work. Later, the project launched pilot projects to initiate new approaches, such as client-based reach and the use of mobile phones.

Outcome

APAC worked with 20 NGOs and reached more than 23,000 FSWs. The program also reduced stigma and facilitated the study of the culture, behavior and needs of sex workers—and recognized this as a public health issue. Training for HCPs (such as for the Master Health Checkup [MHC] project) was broadened to include modules to minimize stigma and discrimination that prevented MARP from seeking health care. In addition, involving the community in planning and developing their own programs resulted in individual success stories as individuals took on new leadership roles.

Table 2 indicates the range of approaches used to identify FSWs and other MARP, and how this information was used to inform programming.

Table 2. Approaches and Steps for Identifying MARP

APAC level	NGO level	Community level
Research Studies and Activities		
Exploratory study Use of snowball technique Mapping of MARP Mystery client approach Observation study Consultative meeting with communities	Community mapping Observation study Hot spot analysis Consultation meeting with primary and secondary target groups (pimps, auto drivers, madams, etc.) Trend analysis with the community on emerging patterns for MARP	Pilot studies for identifying new trends and entrants Site validation of estimated and actual MARP population Identification and referral by community members Line listing of MARP to avoid duplication
Referrals, networking, and linkages to reach MARP		
	Information from clients and secondary target groups Referral from STI clinics and health providers BCC events to reach the hidden population of MARP (e.g. street plays, campaigns)	Peer-to-peer approach Involving local leaders of community (e.g., madams) Hot spot level advocacy Community events and special programs
Training activities		
Training on identification of MARP Guidelines on TI and community mobilization	Training project team Guidance from consultants in PSV and mentoring visits Experience sharing for NGOs and PEs	Peer educator training and support PE and community input to design of materials.

REACHING MSM COMMUNITIES

In Phase II, APAC expanded its TI to reach MSM, working with more than 20 NGOs who focused on MSM. Reaching MSM was challenging because the behavior is highly stigmatized and therefore often hidden. However, a strong sense of identity also exists among some MSM communities, some of which had already formed and registered CBOs. This fit well with APAC's overall approach of community involvement. The project initially supported two MSM CBOs—Sahodaran and the Social Welfare Association for Men—and worked with them to identify service-minded MSM community members as OS and PE to mobilize communities. Community-

developed and community-specific IEC materials were promoted and used widely in interventions.

Outcomes

APAC reached 15,930 MSM with these interventions. This community-based approach was sustainable through an increase in the number of CBOs. Each of the more than 20 MSM NGOs nurtured a CBO in the NGO intervention areas. APAC also directly supported one CBO—ACE—to implement an intervention in Villupuram District.

ThozhaThozha District Level Communication Campaign

In 2009–2010, APAC developed a DLCC campaign, *ThozhaThozah* ("friend of friends") for MSM to enhance awareness of STI/HIV and to address issues of discrimination and stigma. The campaign also motivated MSM to access government health services and CT, and particularly to increase demand for the MHC. The campaign was done in partnership with TANSACS. A secondary target audience was HCPs.

Key features of the campaign were:

- It was a community-driven model. MSM community members played an important role in its design and implementation.
- The primary medium was IPC through PEs (the *thozhas*). Messages focused on HIV/AIDS prevention; accessing STI and HIV testing services; and using condoms and lubricants. The IEC materials were developed in consultation with community members, using local lingo understood by the target community. Two-thousand MSM were selected as *thozhas* and trained to disseminate the key messages to five MSM and five clients.
- A training and mentoring system ensured quality. *Thozhas* participated in a series of one-day training programs, including an introduction to the MHC. Six mentors were also identified to provide ongoing support, themselves supervised by two senior consultants.
- The campaign included advocacy by community leaders and the police.

Outcome

The intervention showed the power of well-timed and tested campaigns, using appropriate media, to push forward project implementation. Involving the community as ambassadors of the campaign resulted in capacity building of the *thozhas* and greater outreach to the hidden MSM population. An evaluation reported that the campaign reached 58% of MSM in APAC intervention districts, of which 80–95% recalled the messages and acted on them. More than 4,000 MSM accessed MHC and ICTC services during the campaign period.

PREVENTION ALONG THE HIGHWAY (PATH)

Truckers and their assistants were one of the first target groups intervened by APAC. To reach this mobile population, APAC conducted a traffic survey of major stopping points (such as motels and fuel stations) and then placed interventions at 11 of these major stops. These interventions were located in such a way that any truck passing through the state would come into contact with at least two interventions. APAC NGOs established drop-in-centers (DiC) and information was provided through PEs, OWs and through self-learning educational games.

Outreach workers and female PEs also targeted FSWs. Beyond highways, the project also supported interventions in towns (Namakal district) that had a high trucking population to reach both truckers and their family members.

Linkages were established to refer drivers to STI care providers along trucking routes. Partnerships were also developed with private agencies—such as Bharath Petroleum, Indian Oil Corporation, Ashok Leyland and Apollo Tyres—to establish clinical services for the truckers (see the subsection on working with the private sector). The strength of this networking system is evident in its sustainability; after the project was withdrawn in 2008, some PE associations continued their interventions (such as the Peer Educators Association in Krishnagiri District, which receives funds from TANSACS).

REACHING OTHER VULNERABLE POPULATIONS

The APAC Project also implemented interventions for slum populations, industrial workers, interstate migrant workers and college youth. These interventions focused on IPC through groups and events to build a supportive environment (such as performances and street theater), to increase knowledge, reduce discrimination, and encourage those at risk to ask for information. The major significance for future programs is to assess the value of these interventions in reducing the risk of infection in low-income and more vulnerable communities. This, in turn, is dependent on the capacity of programs to directly identify MARP.

Interventions with Slum Populations

In Phase I, APAC funded 10 interventions, each covering 45–50 slums, from 1998–2007. These were vast programs (with a target population of approximately 480,000) that targeted high-risk individuals within general events aimed at the overall slum population. Specific activities included developing a family register to facilitate systematic coverage of the population, forming teen clubs for both young men and women, developing a training manual, and developing a DC to provide hands-on training for PEs working in these communities.

Outcomes

Favorable trends were seen in knowledge without misconceptions (from 29% of respondents in 2000 to 80.4% in 2009) and condom use (from 58.4% in 2000 to 88.1% in 2009 for condom use in paid sex). Over 9,000 PEs were selected and nearly 200 teen clubs formed, with 230,400 persons reached with IPC and nearly 10,000 identified as high-risk.

Interventions with Industries

APAC supported eight NGOs in implementing interventions within 320 industries and in work with the local branches of industry associations and unions. Industry had yet to realize the seriousness of HIV/AIDS: correct knowledge and safe sex practices among many workers was low, with high-risk behavior reported among 15% of workers and a high level of discrimination and stigma against HIV/AIDS. These programs required strong advocacy to convince corporate leaders and unions of the need for interventions; negotiate their specific contribution to the program; develop a policy on HIV/AIDS to introduce workplace interventions among workers and contractual workers; and reduce discrimination.

> *"I continue to share information on HIV with truckers, even six years after the project ended. It gives me immense satisfaction to serve them as I could never forget what I learned 10 years ago.*
>
> —Mr.Prabhakar,
> PATH Peer Educator

Outcomes

Among the industries, 310 signed HIV policies in their workplace. Approximately 400,000 workers were reached through the program, with 64,000 workers contacted on an individual basis and nearly 5,000 referred for STI treatment.

SUPPORTIVE INTERVENTIONS: CREATING AN ENABLING ENVIRONMENT

Essential to the APAC Project were advocacy initiatives to change public perception and reduce stigma. APAC used multiple approaches at the national, state, district, and grassroots levels, with secondary and tertiary stakeholders, to position HIV prevention and care as an important social intervention.

These advocacy initiatives involved state and local government departments, elected representatives, faith-based organizations (FBO), health care institutions, the police, the media, and the general public. Advocacy to fight demeaning social conditions and stigma was proactive, ongoing, and widespread. It contributed to changes in policy and practice that facilitated programs in the initial years.

Advocacy approaches included:

- At the field/district level:
  - APAC and NGO staff consistently worked with TANSACS, state and local officials, and community leaders. The project also introduced innovative concepts such as a monthly advocacy calendar, in which sub-grantees developed a plan for when key officials would visit their DiC and interact with the target community; it also introduced a network marker, in which color codes were assigned to stakeholders to indicate their understanding and support for activities to improve advocacy for MARP programs.
  - Advisory committees were created within each intervention, with members from various categories of MARP involved in mobilizing support and encouraging commitment within these groups.
  - NGOs engaged the district collector and senior functionaries of the district in launching their programs, leading to increased local ownership of programs.
- At the state/national level:
  - APAC supported the development of formal HIV/AIDS policies by FBOs, health care facilities, and work places.
  - Media representatives were trained, followed by ongoing interaction with and guidance to the media.
  - The project supported campaigns, exhibitions, and community events aimed at the general public to reduce stigma and discrimination of PLWHA and MARP.
  - PLWHA were involved and trained as ambassadors to promote acceptance of and knowledge about HIV/AIDS.
  - Activities involved celebrities to increase public visibility.

The advocacy activities contributed to:

- Adoption of positive policies on HIV/AIDS
- Change in the media's representation of PLWHA and FSWs and in wider reporting on HIV/AIDS
- Reduction in harassment of FSWs and MSM

- Change in the attitudes of HCPs and support for the delivery of non-stigmatized services
- An improved enabling environment to effectively plan and carry out activities
- Development of linkages with other welfare programs for addressing non-pragmatic needs
- Gradual change in the self-image of MARP and reduced shame and secrecy

BCC SUPPORT FOR THE PREVENTION TO CARE CONTINUUM

APAC was a leader in the development of communication materials and approaches to prevention and care interventions with MARP. Using a systematic process that involved needs assessment studies, community input, pre-testing, and evaluation and research studies, the project developed a series of audience-specific communication materials. Materials covered a wide range of needs—creating awareness, influencing attitudes, and supporting skills development—and a range of circumstances, including exhibition booths, trains, street performances, and personal use. Materials were updated and revised to reduce message fatigue and address emerging myths and misconceptions. These bold and innovative communication campaigns at the district and state levels included the "Behave Responsibly" campaign; the DOSTH condom promotion campaign; and a campaign on voluntary counseling and testing and on stigma.

This expertise was shared through TA at the national and state levels and through APAC's policy of free, fast distribution of materials. There was a strong partnership with the SACS in Tamil Nadu and Puducherry to support the state's communication priorities and share IEC materials and designs for replication. At the national level, APAC was part of NACO's BCC working group and planned for a national BCC Resource Center. APAC also developed training materials in BCC for different target audiences; initiated a TOT approach; and trained community members. For example, three resource and training centres (RTCs) provided TOT on street theater and traditional media. Examples of communications materials created for the project are included in Annex H.

CHANGING TIMES: NEW APPROACHES TO PREVENTION

The Need: A Master Health Checkup for MARP

Evidence indicated that only 30% of MARP accessed STI clinic services, of which only 30% accessed services in government facilities when symptomatic.[8] The barriers to using government services perceived by MARP included stigma and discrimination at facilities, lack of comprehensive services, and distance and timing of services. To address this high-priority need, APAC developed a large-scale, innovative MHC program.

In collaboration with TANSACS and the Tamil Nadu AIDS Initiative (TAI), the project managed the government's MHC program to motivate MARP in 32 districts of Tamil Nadu to access health services in government hospitals. The MHC included screening for various STIs, HIV, and cervical cancer in addition to a general checkup. It also involved a new method of registering individual MARP and line listing. The goal was to achieve saturated coverage of clinical services for MARP through improved services without stigma and discrimination on the part of health providers.

With support from TANSACS, APAC and TAI, 110 NGOs implemented TIs for MARP in Tamil Nadu. The TIs created demand, through counseling and mobilizing MARP, for MHC services. Funding (USD $850,000) was provided by TANSACs and APAC managed the project in 95 STI-specific clinics and 50 health clinics that offered STI services.

[8]STI clinic data, TANSACS.

The Process for MHC Implementation

- A new system of listing MARP that included stronger individual identification (confidentiality was still protected with an ID number). Line listing avoided duplication; increased the accuracy of assessing the number of MARP; and facilitated follow-up. While existing mapping data indicated around 110,000 MARP, this new system showed 90,000.
- APAC conducted an assessment of all 145 government STI clinics in Tamil Nadu to identify gaps in infrastructure and human resources. Based on findings, infrastructure, facilities, equipment, instruments, and consumables were supplied to all clinics; staff support was increased through government funding.
- APAC organized training programs for medical officers, nurses, laboratory technicians, counselors, and NGO staff on the MHC program. Training focused on technical information and provision of a supportive environment. APAC also trained 30 clinic mentors and 600 HCP and provided mentoring support to all STI clinics.

Outcomes

- From 2010–2011, TANSACS established 50 additional STI clinics in upgraded primary health centers to ensure adequate coverage. APAC introduced a task-sharing initiative for nurses to enhance program quality. The process involved development of STI clinic operational guidelines, an STI training module for HCP, and IEC materials.
- Between September 2009 and March 2011, 28,095 FSWs and 19,083 MSM accessed services provided by the MHC program. Of these, 13,610 MARPS 7,747 FSWs and 5,836 MSM were from APAC districts—the program reached 74% of line-listed MARP.

Key Learnings

- This program generated a large pool of data related to MARP, which helped the state understand the current epidemiological situation for STIs, HIV, and non-communicable diseases. The effective management of the program, through a multi-pronged approach that addresses systems, processes and procedures, is a model that can be replicated in other settings.

REACHING UNREACHED SEX WORKERS (RUSE) THROUGH A CLIENT-BASED APPROACH

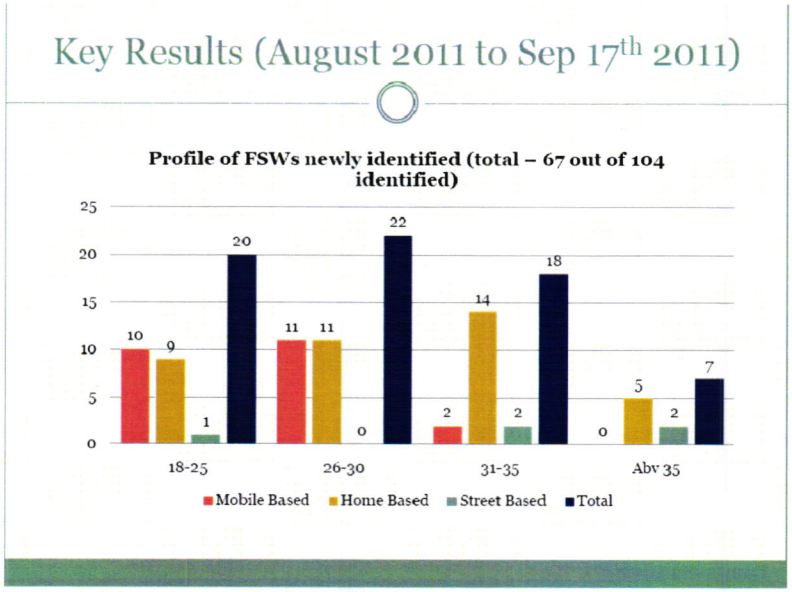
Sex work has shifted into homes—and away from brothels and streets[9]— with the advent of low-cost mobile phones, which allow many clients and sex workers to solicit sex via telephone and avoid street work. Existing mapping and PE programs focused mostly on street- and brothel-based sex work. With the view to reaching new sex workers, the project piloted a new approach of engaging regular clients of sex workers to identify other sex workers from whom they seek sex in intervention areas.

APAC piloted a project to reach these hidden sex workers by asking regular clients to identify other sex workers from whom they seek sex. The initiative (RUSE) was piloted in Kanyakumari district, in the south of Tamil Nadu, and was rolled out in three stages. First wasa meeting with NGO staff and PEs to articulate a strategy. The second task was to identify PEs to be involved. Third, there was the actual roll-out of the initiative and a review of results. Feasibility was measured in terms of number of clients identified and number of FSWs registered by the projects. The initiative adopted a two-tier approach: Registered PEs and sex workers (less than 25 years old) contacted regular clients; the men, in turn, contacted sex workers and peers that they knew and referred them back to the PEs (see Figure 9).

[9] Low-cost mobile phones allow clients and FSWs to connect via phone—and no longer on the street.

Weekly reviews over a month showed that the three interventions in the district had identified 42 clients and 104 FSWs. Cross verification with existing records showed that 67 of the FSWs had never been registered with any of the intervention projects in the district. The success of this initiative is exemplified by its short time frame and the fact that there was no separate allocation of staff/peers.

Figure 9. Profile of Newly Identified FSWs



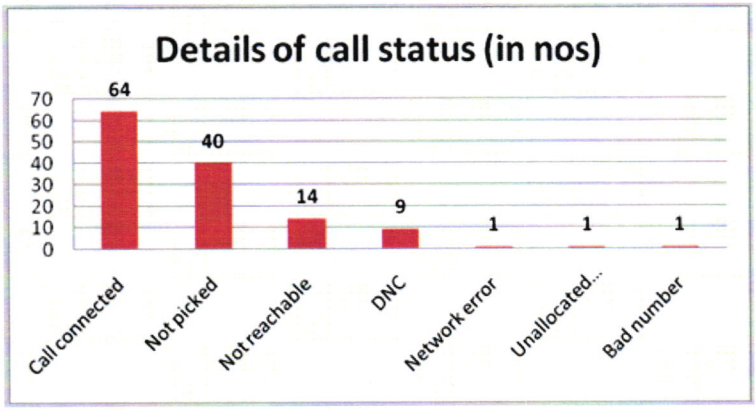
USING VOICE-BASED SMS TO REACH MARP

As mobile phones became popular for connecting FSWs and MARP with their clients, opportunities for direct contact and outreach became more limited. While many FSWs report that this has made their work easier, this has posed a challenge in terms of providing services and motivating MARP to utilize services. In response, APAC launched an initiative to reach registered sex workers via mobile phone (see Figure 10).

The initiative was piloted in the district of Kancheepuram among FSWs who agreed to receive voice-based SMS. (A text-based SMS strategy was abandoned because of compatibility issues.) Messages focused on prevention and included such topics as STI/HIV testing, cervical cancer, condom use, and regular medical checkups. Ten such messages were branded as messages from *arokyaanjalai,* and a single message was sent in a day. The same one message was relayed three times in a month, every ten days. These messages could also serve as reminders for MARP who have upcoming periodic checkups; as well as reinforce outreach messages from PEs and organizations.

APAC was provided direct access to the servers from where the messages could be relayed to specific numbers; the server was username- and password-protected, and mobile numbers were used without names to further ensure confidentiality. These SMS messages were sent to 118 FSWs; initially 75% of the calls were picked up with 64% picked up by the third repetitive message. More messages were picked up in the afternoon vs. the morning and around 45% of FSWs listened to most of or the complete message. The pre-paid package cost 8 PS per answered call and access to the software and server was included.

Figure 10. Details of SMS Messages

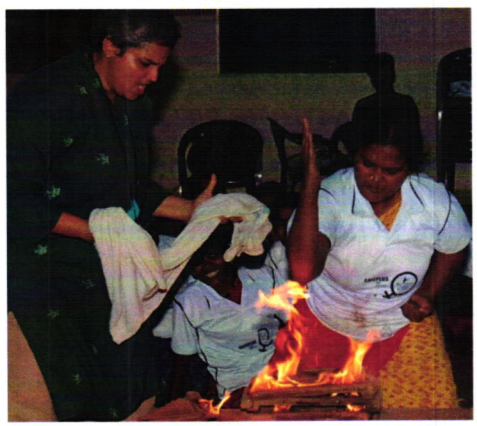


How the Voice-based SMS is Relayed

Messages/Mobile numbers/Scheduling of calls controlled by APAC	Servers of voice SMS, information is secure and password protected.	Mobile phone of the FSW receives the call

SAFE+

Figure 11. Learning Self-defense Techniques



To protect young sex workers, new to the trade and especially vulnerable to violence and HIV-related risks, APAC introduced a pilot program to teach them self-defense techniques in order to fend off violence and other threats to their safety and well-being. Sex workers reported physical, mental and sexual harassment by police, criminals, and their clients. Those who participated in the training reported that they felt they were able to handle violence more effectively.

REACHING RURAL MARP: LINK WORKERS SCHEME

NACP III focused on reaching rural MARP, as prevalence studies showed that 59% of total infections existed in rural areas where ignorance and stigma surrounding HIV/AIDS is high.

Figure 12. Link Workers Addressing NREGA

In 2009, and with funding from NACO, APAC implemented pilot projects for the LW scheme in four districts. Following this success, the scheme was launched in 17 additional districts with a high prevalence of HIV. A mapping exercise identified 100 high-risk villages within each district; situation and needs assessment was then conducted within each village to estimate high-risk populations and PLWHA. Link workers (chosen in consultation with village health committees [VHC]) then identified and provided outreach and referrals to MARP and PLWHA living in the identified high-risk villages. Link workers are trained to refer high-risk individuals to the nearby STI and ICT centers of the government. BCC resources developed by APAC were provided by TANSACs, supported by a communication-on-wheels approach.

APAC also partnered with established NGOs for district-level work based on their rural experience, access to self-help groups, and leadership. These partnerships bolstered rapport with *Panchayath* leadership and with existing VHCs.

Figure 13. Wall Writing by PRI

The initial creation and capacity building of VHCs within the villages contributed to community acceptance and an efficient program rollout. Members of VHCs included nurses, Anganwadi workers, ward members, teachers, self-help group members, and local informal leaders. PLWHA are also included as members of village health committees to sensitize groups and contribute to important committee decision-making. This inclusive approach, combined with close collaboration with the Anganwadi workers who were also trained on HIV/AIDS, also contributed to efficient program implementation and access to HRGs.

APAC established 1,459 VHCs, headed by the *Panchayat*president, which met every month. Further, 2,736 Red Ribbon clubs were created; through these clubs, young men and women participated in training from ILFS, CED in entrepreneurial and lifestyle skills and became capable of starting their own businesses with loans from the government program.

In some villages, condom outlets are managed by the women's self-help groups.

The APAC model of training, mentoring, monitoring and exchange visits ensured ongoing support to LWs. To build capacity, APAC trained LWs to take a leading role in managing the community program as well as participate in research and planning, a system developed after a polling booth survey. Link workers helped to analyze and interpret the data and decide on next

steps for micro planning. Further, 10 LWs were trained as supervisors for their career growth (LWs are often recruited as government Anganwadi workers).

Figure 14. Contributions for PLWHA

APAC provided the technical support that demonstrated the value of the LW program. To further support the program, 1,800 village libraries were used as information centers, with village librarians responsible for maintaining IEC materials. Community resources were leveraged to support the program, including a *Panchayat*contribution of 1.5 million INR to support education (training, school supplies, and uniforms) for children of HIV-positive parents; while community members donated food. In one village, PLWHA were provided with a house from by the government. Overall, the LW scheme empowered villages to take responsibility for a comprehensive approach to HIV/AIDS.

CARE AND TREATMENT MODELS

When APAC began, only a limited number of public hospitals, international NGOs, FBOs, and PLWHA organizations provided care for PLWHA. Care and support was not in APAC's initial mandate; however, this changed during Phase II, the project explored the avenues to provide care and support to HIV-infected people. Because the government took a lead role in care and treatment, APAC focused its care efforts on six broad areas: (1) provision of home-based care; (2) engagement of private HCPs; (3) programs for HIV-positive and affected OVC; (4) targeted care, treatment, and support services for HIV-positive individuals within MARP; (5) strengthening of capacity of PLWHA networks for advocacy and social support; and (6) generation of evidence on care programs.

APAC's care and support services were informed by the application of an evidence-based, systematic approach, with a strong emphasis on training and support for community interventions. The project's service provision was guided by the following:

- Flexibility to respond to emerging state and program needs and avoid duplication.
- A focus on women and children.
- Effective engagement with the private medical sector.
- Capacity building of local institutions and individuals through training, mentoring, and exchange.
- Support for PLWHA networks to build capacity and addressing stigma and discrimination.

ACHIEVEMENTS

- APAC was flexible and deftly responded to changes in policy and coverage by the government and donor. For example, in Phase II, APAC expanded its program to include NGO programs for PLWHA care and support; these programs were later transitioned when government services expanded under NACP III.
- From 2004 to 2008, APAC supported a home-based care program in six districts, which filled a gap in provision of services for PLWHA. The program reached 10,526 PLWHA and

referred them to services, and trained 5,500 family members on home care. Based on this program, APAC developed a minimum package of care services for the state.

- To support the capacity and sustainability of PLWHA networks, APAC trained 90 governing board members of positive networks in management and good governance practices. This included development of a training module on CBO management..
- APAC served as the lead agency in developing sustainable support for orphans and vulnerable children through the OVC Trust, which is supported by a corpus fund of five crores ($1.25 million).
- In partnership with a private hospital, IRT Perunderai, APAC developed a network model that strengthened care and treatment for HIV/AIDS in the Erode district of Tamil Nadu. The model demonstrated that quality treatment and care for HIV/AIDS could be expanded at the district level by linking centers with high-quality services and training with a network of private hospitals to support follow-up care.
- Over the life of the project, APAC trained 20,000 HCPs in care and support, and developed training modules that were adopted for use at state and national levels.

PROVIDING HOME-BASED CARE

APAC funded the Home-based Care (HBC) program from 2004 to 2008 in six districts, selected on the basis of HIV prevalence. Initially, few public service centers existed for CT, ART, and follow-up care. The HBC program aimed to provide PLWHA with access to care and treatment facilities and a supportive environment free of discrimination and stigma.

Lack of awareness and the stigma associated with HIV/AIDS contributed to poor access to care and treatment for PLWHA. This led to increased morbidity and mortality, which in turn negatively impacted the social and financial status of families. The project's goal was to identify PLWHA early and link them to services; encourage them to access services, including testing in government centers; and, since services were limited, train caregivers and families to provide care beyond the hospital. Six district and two blocks per district were selected for the program.

Those who were HIV-positive enrolled in the program at testing centers. ORWs followed up with them, counseling on disclosure to the family and sensitizing the community. ORWs conducted a series of trainings for family members on home care and prevention of opportunistic infections; drug adherence; nutrition with locally available food; livelihood options; end-of-life care; and post-death care.

By 2008, the state increased its services for PLWHA and established 15 public-service ART centers and 25 community care centers. Thus, there was a less urgent need for the HBC program. Based on the lessons learned from this project, APAC developed a minimum package of care services for the state, which was adopted by all partners implementing home care. The HBC Project also informed APAC's understanding of the issues facing OVC and their families and contributed to the development of the OVC Trust.

> *"The home-based care program was unique in the sense that it gave the opportunity for the NGO to provide direct services to PLHA. We were able to educate the families and the society on acceptance of PLWHA in the community. The livelihood support helped nearly 45 widows enrolled in our project to lead a self-sustained life"*
>
> —Mr.Sakthivel, Director, MGENM (NGO supported by APAC), Namakkal

ENGAGING PRIVATE HCPS FOR PROVISION OF CARE AND TREATMENT

Most HRGs accessed health services from local service providers. Therefore, APAC focused on (1) increasing the competence of these providers, who were the entry points for HRGs to access HIV services; and (2) addressing other challenges that prevented MARP from using both public and private services, including stigmatization by providers, lack of privacy, and limited hours of operation. APAC was successful in working with TANSACS to expand the provision of high-quality services in the private sector, but only in a relatively small segment. Engaging and ensuring quality in the private sector remains a challenge. Engaging private HCPs used three major approaches:

- Identifying and strengthening private clinics and facilities (see "Case Study 1: Improving ICTC in the Private Sector" in Appendix E).
- Setting up training centers (see "Case Study 2: A Network Model for PLWHA Treatment: IRT Perunderai Hospital" in Appendix E).
- Creating a linked district network based on a central private hospital.

Further, in 2002 APAC set up five CETCs in private hospitals and institutions. The goal was to train five categories of providers—allopathic practitioners, registered indigenous practitioners, nurses, antenatal midwives, and pharmacists—on identification and referral and STI and HIV/AIDS management. While the program was an innovative partnership, APAC's 2004 STI Healthcare Provider Survey found that only 10% of trained practitioners were providing correct treatment. Based on this and other research findings, APAC refined its strategy to work with community-preferred practitioners identified by MARP and PLWHAs.

In 2008, APAC started the Nakshatra Plus program to build the capacity of private providers and increase access to comprehensive care services for MARP and PLWHA. In partnership with TANSACS, APAC identified 110 clinics for training, infrastructure and supplies support, and branded them as Nakshatra Plus (see the report subsection on the private sector).

OVC TRUST: SUSTAINABLE SUPPORT TO OVC IN TAMIL NADU

It is estimated that there are over 8,000 children living with HIV in Tamil Nadu, with 1,900 children on ART. Although the government has institutionalized prevention of parent-to-child HIV transmission (PPTCT) and ART programs, the state lacks a system to meet the real needs of education, nutrition, and socio-economic assistance needs of all HIV-affected children. To address the need, APAC conceptualized the Tamil Nadu Trust for Children Affected by AIDS (TNTCAA), known as the OVC Trust.

The concept was shared with TANSACS and the Ministry of Health and Family Welfare approved the program. To garner political support and ensure sustainability, the proposal was presented to the state assembly and approved by the government of Tamil Nadu, which awarded five crores ($1.25 million) to support the trust. The trust is chaired by the Secretary of Health and Family Welfare, Tamil Nadu; the Managing Trustee is the project director of TANSACS. Representation from other allied departments constitutes the board of trustees. The trust uses the interest generated from the award to support the educational, medical, nutrition, and socio-economic needs of 20% of children in the state who applied (1,500 of 8,000 children). Preference is given to HIV-positive and double-orphan children. Each child is given 2,000 INR annually and the support continues through age 18. The trust has reached 20% of OVC in the state. APAC provided technical and secretarial support to manage the trust's activities. APAC conducted an assessment of trust activities and found that it had benefited children from the lower economic sections of the society; that said, a large number of children are not covered by

the program. The study recommended an increase in the funding to reach all OVC in the state. APAC has been working with TANSACS and the government to increase the funding.

TARGETED CARE, TREATMENT, AND SUPPORT SERVICES FOR HIV-POSITIVE MARP

In India, FSWs account for 0.5% of the adult female population, but make up 7% of PLWHA. While the national strategy has plans to link HIV-positive FSWs to care and support services, implementation has focused on HIV testing. Thus, targeted interventions have developed strategies to mobilize sex workers for testing, but holistic interventions after following testing are not easily available.

To meet this need, APAC piloted the Comprehensive Care and Livelihood Support (Shakthi +) program, exclusively designed for HIV-positive FSWs. This process-based approach is an innovative way to address the needs of a highly vulnerable group. It promotes strong collaboration across NGOs, educational institutions, government departments, and MARP (see "Case Study 3: Improving Physical, Social and Economic Resilience: A Pilot Program for HIV-Positive Sex Workers" in Appendix E).

SUPPORT FOR PLWHA NETWORKS

People living with HIV/AIDS are vulnerable to stigma and discrimination, family exclusion, poverty, and (especially in the case of women) limited access to treatment and care services. To address these vulnerabilities, APAC built the capacity of networks and covered both organizational and communication approaches to reduce stigma.

In 2007, APAC supported the Indian Network of Positives (INP+) to train 20 district-level PLWHA members on components of home-based care such as nutrition, treatment preparedness, ART adherence, and end-of-life care. The participants disseminated the training to more than 1,000 family members of PLHA across 20 districts.

In 2008, APAC partnered with Tamil Nadu Networking of People Living with HIV (TNNP+), a state-level community organization, to build the capacity of governing body members (from nine districts) in CBO management, finance management, governance, documentation and communication.

A training module on CBO management was developed exclusively for HIV-positive networks. Ninety people participated in training, which enabled networks to strengthen their administrative and financial systems. TANSACS selected five networks that participated in the training to run DiCs in their respective districts. External consultants who evaluated the CBO training program recommended replicating the training for other district-level networks. APAC thereby supported TNNP+ in extending the training to eight new district-level networks the following year.

APAC also encouraged networks to undertake research studies on PLWHA. APAC built the capacity of networks with basic research methodology and small grants to cover operational costs. Networks were involved with conceptualization, tool development, and data collection. TNNP+ and Positive Women Network (PWN+) were involved in the "Willingness to Pay" study, which examined the amount spent by PLWHA on in- and out-of-pocket expenses, including medicines and other services related to health care. Based on the findings, APAC developed and implemented Nakshatra clinics. APAC also involved PWN+ in two other studies—"Reproductive Health of Women" and "Insurance Model."

In addition, APAC developed a campaign against stigma, "I am able to live," using PLWHA as ambassadors. Health communication materials supported a message of positive living and prevention, which was also fostered through trainings on stigma reduction for NGOs, self-help groups, medical professionals, and faith-based groups.

GENERATING GREATER EVIDENCE ON CARE PROGRAMS

APAC conducted research studies to understand the needs of target communities and develop effective responses that focused on developing a community-friendly program and meeting unmet needs. For example, "Risk Assessment of People Living with HIV/AIDS" explored the level of knowledge among PLWHA on transmission and prevention of HIV/AIDS as well as their adherence to safe sex practices. It also examined the stigma and discrimination faced by PLWHA and their quality of life. "Reproductive, Child and Sexual Health Needs of Women Living with HIV/AIDS" contributed to innovative initiatives such as Shakthi+ and the literacy program. "Willingness to Pay by PLWHA for Private Medical Services" helped APAC design PPP initiatives to meet the need of the PLWHA community.

LESSONS LEARNED FROM APAC'S PREVENTION AND CARE MODELS

- Ongoing research on the knowledge, attitudes, and behavior of target populations, employing both quantitative and qualitative methodologies, is an essential foundation for program development.
- Sound standardized systems for training, support, monitoring, motivation, and exchange are key components for the internalization of messages and sustainable behavior change.
- Communication to support behavior change should be varied and inventive to minimize the monotony of messages. Easy access to and widespread, quick dissemination of IEC materials is important.
- Giving community members increased responsibility in decision-making promotes individual growth and community mobilization.
- Ongoing long-term advocacy with political, community, and other opinion leaders is an essential component of effective communication. Use of public campaigns and the media builds a supportive environment among the general public.
- Programs should be regularly monitored to assess progress, but sustainable behavior change may require long-term commitment. Pilot projects (such as RUSE) can identify challenges and good practices for replication, as well as test the applicability of good models in different settings.
- Ensuring that MARP access health services regularly in both the public and private sectors remains a challenge: times of service, provider attitudes—and perceptions of those attitudes—and the motivation of MARP all act as barriers. APAC has worked with the government to address these problems.
- Working with government to develop the OVC Trust was an innovation that demonstrated the use of state funding to create a sustainable response to the emerging social needs of OVC and their families.

IV. GENDER MAINSTREAMING

In Phase III, as mandated by the tripartite agreement, APAC started to mainstream gender into its program and those of its partners. This was done in a systematic manner through the review of existing policies and development of an HR strategy to ensure that the organization is gender balanced; building capacity in gender sensitivity and analysis; and designing supportive monitoring and governance systems to ensure compliance at both the project and partner levels.

APAC'S SYSTEMATIC APPROACH TO GENDER MAINSTREAMING—PHASE III

Figure 15. APAC's Approach to Gender Mainstreaming

Policies & Programs	Capacity Building (CB)	Special Initiatives
• Analysis of existing policies • Development/modification of gender sensitive policies at APAC and NGO level • HR strategy to promote women in decision making level across APAC ecosystem • Integration of gender in program strategy: a) MHC; b) Safe + ; c) Shakthi+ ; d) Learning to Change; e) gender mainstreaming pilot program	• Training in gender sensitization and analysis • Training and TA in data collection and use of sex-disaggregated data • Gender training modules developed (3)	• Gender audit to assess knowledge , attitude and practice among health service providers • Strategy for NRHM on training of health care providers

The International Center for Research of Women (ICRW) provided TA to integrate gender-sensitive approaches into existing prevention and care programs.As a first step, ICRW conducted an organizational gender analysis in one of APAC's slum intervention programs. Based on this experience and discussions with staff and partners, a strategy for gender mainstreaming was developed. This included dissemination of learning to NGO partners and SACS; and sensitization of project staff, HCPs and community and policymakers on gender issues.

To complement its organizational mainstreaming efforts, APAC supported a panel of women lawyers in each intervention district to address and protect women's rights. They also explored linkages with the Mission's legal rights and anti-trafficking programs.

ACHIEVEMENTS

- 326 people were trained in gender sensitization.
- 26 NGO/CBO partners were trained in gender sensitization.
- 26 gender policies were developed by NGOs or CBOs.

- 5 technical assistance sessions were provided by a panel of women lawyers.
- 62 issues (such as violence, thrown out of family home, inheritance) were mediated.

Gender Audit Initiative

APAC initiated a gender audit to assess gender inequity and sensitivity among health facilities in Tamil Nadu. The objectives of the audit were:

- To study existing policies and practices and examine centrality of the women's agenda across policies, programs, and implementation in Tamil Nadu's health system.
- To analyze facilities available at primary level as well as secondary-care hospitals (through available secondary data) that allow women to access services in public and private health service facilities.
- To assess staff knowledge, attitudes, and capacity with regard to gender in both public and private hospitals.
- To analyze the proportion of women in key decision-making positions within the health care system and their impact on gender mainstreaming (if any).
- To examine women's participation and ownership of village-level health planning and monitoring.
- To recommend strategies to further mainstream gender in the health care system.

This study produced an audit of the facility-based determinants that constrain women from accessing health care in Tamil Nadu. It assessed the current trend of gender inequity and sensitivity within health care facilities, both public and private, and determined the issues faced by the target groups who are able to access health care. Second, it assessed equity and sensitivity among health service providers.

Although this did not address the macro-level issues of gender inequity in health care, the audit can help promote gender equity in areas that are within service providers' managerial control.

Process

The initiative included a primary and secondary data review with in-depth interviews of policymakers and HCPs, including139 Anganwadi workers, 391 nurses, 82 grade IV staff, and 189 doctors at 45 public and private health care facilities. In addition, focus group discussions and in-depth interviews were conducted with policy-makers, community members, and elected members. A technical committee comprised of NRHM representatives, subject experts, and others was organized to help in data analysis and develop policy recommendations.

Outcome

The audit produced data about the factors that affect access to health care for women in health facilities. The information will be used to evolve a policy strategy to improve the capacity of health service providers in gender. A training plan will be developed for the state to train 40,000 HCPs on gender issues with funding from NRHM.

In addition, the results will be disseminated to HCPs so that they are aware of ways in which they can improve gender equality and sensitivity within their facilities. This initiative is expected to lead to a health system that is more sensitive to the particular needs of women.

"The women came out of their shells and stood on their own to fight for their rights and against sexual exploitation."

—Selvi J. Sundarakani, Project Manager, PACHE Trust

V. TECHNICAL ASSISTANCE TO GOVERNMENT AND CSOs

INTRODUCTION

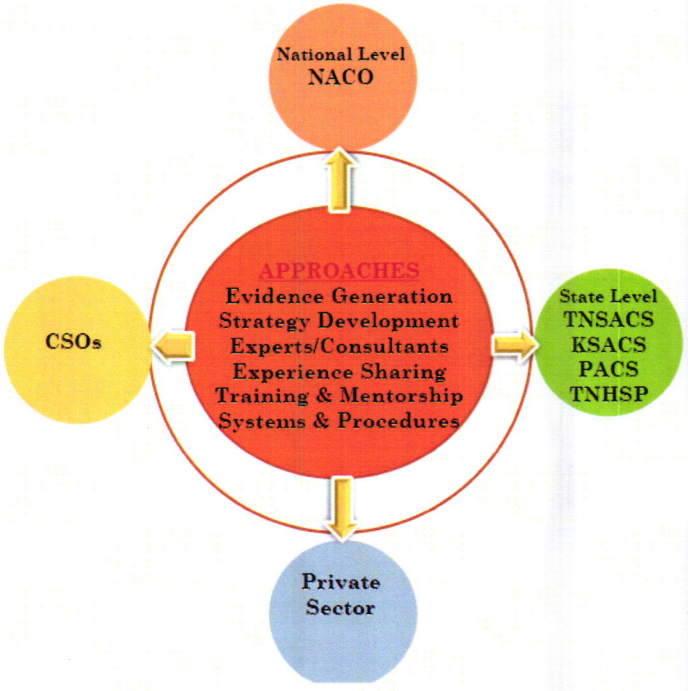
From the outset, APAC recognized that, to achieve long-term success in reversing the HIV/AIDS epidemic, it was necessary to ensure sustainable projects, systems, and technical skills supported by governmental and organizational policies.

With financial assistance from USAID, APAC initially invested in development of its own staff, partners and consultants through a comprehensive capacity-building approach that included training, mentoring, joint planning and field visits, exposure visits, and participation in regional, national, and international conferences. One critical aspect of success was the conscious effort to develop meaningful and lasting relationships beyond short-term training and mentoring. This partnership approach included the long-term mentoring and follow-up TS that ensured that skills were internalized and utilized by recipient organizations and their staff.

APAC also recognized early that it needed to extend its capacity development beyond its own staff and consultants in order to provide TA to the large number of organizations that sought its help. To this end, APAC worked to build the capacity of research and training institutions that had both a mandate from the GOI and the potential to serve a larger number of organizations. These institutions served as multipliers of APAC's high-quality TA effort and are recognized by NACO/SACS as resources in the continued fight against HIV/AIDS.

Figure 16. APAC and Its Technical Support Service Clients

Figure 16 presents APAC at the core with the technical support services that it has provided, including assistance to 35 training and research institutions over the past 17 years.



APAC's multi-pronged approach to building the capacity of its staff and consultants and, in turn, the capacity of training and research organizations, has had a far greater impact than APAC would have achieved had it limited its focus on itself. Successful partnerships with three main entities—the government, the private sector, and CSOs—were all integral to APAC's success. As a result of its partnership with the government, systematized provision of TA, training, mentoring, exposure visits, experiential sharing, and other mechanisms at the field level, the project director of the TNHSP requested that APAC work on broader

health systems strengthening issues, such as conducting a facilities assessment on bio-medical waste management and a gender audit.

GUIDING PRINCIPLES FOR TECHNICAL SUPPORT

Guiding principles for TS include the following:

- **Multi-pronged approach to capacity building of partners.** APAC tailored its TA to the diverse needs of partner organizations. This included sharing experiences, providing field support, building capacity, and advocating for policy change.
- **Partnering with institutions to provide training and TA.** APAC focused on building partnerships with institutions to increase its coverage and build on the capacity of additional organizations.
- **Involvement of the community and NGOs in program design**. APAC involved communities and NGOs in all stages of program and initiative design and implementation to facilitate ownership and sustainability.
- **Customized training for CSOs based on thematic interventions.** APAC customized its capacity building and technical support on the basis of need of organizations.
- **Continuous provision of TA and training at regular intervals, including mentoring and follow-up.** APAC understood that providing capacity building/technical assistance is a continuous process that needs to be supported by on-field support and mentoring to achieve the desired results.

KEY ACHIEVEMENTS

The project's key TA achievements of TA include the following:

- APAC influenced policy design at the national level to incorporate some of APAC's learning into the national program. Several of the project's tools, including its NGO selection tool, were modified and incorporated into NACO's operational guidelines.
- APAC successfully supported NACO in scaling up and strengthening the country's HIV/AIDS program. Assigning consultants to support SIMS's development and folk media campaign rollout, strengthening DAPCUs, along with its contribution in TI and surveillance, had significant impact.
- APAC was successful in transferring its learning, systems, and experiences to SACS; TNSACS adopted several of the APAC's practices, including the NGO selection tool and experience-sharing mechanism to strengthen the state's program.
- Innovative initiatives, including setting up SHCRCs and SHDRCs, within existing public institutions, will make a significant contribution to strengthening the state's public health programs over the long term.
- APAC has built the capacity of numerous NGOs and community members, which has contributed in improving implementation of public health programs and other social programs in the state.

TECHNICAL ASSISTANCE TO GOVERNMENT

Technical Assistance to National AIDS Control Organization

Starting in Phase II, APAC provided three different types of TA at the national level:

1. Participation in the NACP II, III and IV working groups as chair people, coordinators, or members—contributing to shaping policies and guidelines at the national level.
2. Organization of theme-based, experience-sharing workshops, conferences and events for cross-learning and exchange. These initiatives facilitated a greater understanding of field issues and solutions—and helped avoid duplication of effort. Some of the major programs organized by APAC include: the National Communication Officers Workshop; the National State AIDS Control Societies' Project Directors Conference; and the National TSU Experience Sharing Meeting. APAC also organized several international workshops on MARP-focused programs including the Monitoring and Evaluation Workshop on MARP, which brought together program managers from different countries to share experience and evolve newer program monitoring indicators. APAC also disseminates its research and program activities nationally to influence programs and policy change.
3. Support for the areas of communication and strategic information over the medium and long term. The project supported NACO in the design, planning, rollout, and evaluation of the folk media campaign—establishing a national HIV/AIDS communication resource center and supporting experts in research activities, including data triangulation.

APAC's key contributions at the national level include the following:

Support in strengthening the TI program. A pioneer in working with MARP and in evidence-based planning, APAC made significant contributions in the design and implementation of NACP II, III and IV. APAC chaired the Technical Resource Group on TIs in NACP II and served as vice-chair in NACP III. During Phases I and II, the project established three demonstration centers and trained NGO and SACS officials across the country. Several of APAC's staff also visited NACO and other states to develop guidelines on TI projects and review their programs. Several of APAC's practices became part of the National AIDS Control Program.

Support in strengthening M&E and surveillance. APAC's experience in conducting behavioral surveillance and developing systems for effective monitoring are well recognized. APAC shared its learning with NACO, which was included in the operational guidelines for conducting the BSS in the country. APAC supported consultants at NACO in developing data triangulation tools, analyzing information, and to re-categorizing districts based on prevalence and vulnerability factors. APAC also supported data triangulation efforts in several states, including Tamil Nadu, Uttar Pradesh, and Uttarakhand.

Support in communication initiatives. APAC's communication strategies, programs, and materials are well recognized. APAC acted as chair of NACP III's working group on communication; and participated in NACP IV's working group on communication and advocacy, social mobilization, gender and youth, greater involvement of people with HIV/AIDS (GIPA), eliminating stigma and discrimination, and mainstreaming. APAC also supported NACO in conceptualizing, designing, implementing, monitoring, and evaluating folk media campaign in the country (see below). APAC has assisted NACO in establishing the National HIV/AIDS Communication Resource Centre (NHCRC), which will serve as the repository for all communication materials related to HIV/AIDS in the country and will also conduct related research and material development. Finally, the Planning Commission of India invited APAC to join the subgroup on HIV/AIDS to develop country's 12th five-year plan.

Support NACO in its roll out of a national, folk media campaign. Folk media is a useful medium to reach unreached populations and target groups. Traditionally, folk media is a strong, adaptable, and effective way to mobilize community opinions and action for social causes. Because of APAC's significant experience using folk media to deliver messages related to HIV, NACO asked for support in rolling out its campaign nationally. The campaign objective was to increase and sustain awareness on HIV/AIDS among MARP and generate demand for services through the delivery of standardized messages, building capacity of local teams, and developing a network of folk teams.

To support the campaign rollout, APAC developed the appropriate systems, operational guidelines, and M&E tools; it provided two consultants to provide TA to NACO; and it organized three national workshops in partnership with NACO. The rollout included three phases—Phases I and II included eight states each, while Phase III included six additional states. Key highlights of the campaign included:

- Use of state-specific folk messages;
- Standardized and target-specific messages;
- Capacity-building and use of local talents;
- Performances in strategic locations;
- Awareness, demand generation, and linkages with services;
- Involvement of district support team in planning and monitoring; and
- Impact assessment.

The project trained 106 resource people at the state level (they further trained the district teams); 47 folk forms were used; 166 scripts and songs were developed; and 41,844 performances were planned across the country. At the time of the writing of this report, an evaluation of the campaign was planned for December 2011.

Technical Assistance to Tamil Nadu State AIDS Control Society

From the start, APAC worked closely with the SACS to share its learning, experiences, research, and skills. APAC also supported SACS in scaling-up and improving quality of TI programs in the state, as well as provided consultants to strengthen its functioning. Key areas of support for SACS included:

- Established the TSUs for the state.
- Supported its state-specific communication strategy.
- Shared its systems (NGO selection process and ESRM among partners), which SACS adapted for use.
- Supported establishment of ICTC and STI clinics in the private sector.
- Supported the design and implementation of the MHC program.
- Conceptualized, implemented, and transitioned Hello+ Helpline to the SACS.
- Provided consultants to support implementation of IEC activities and and M&E systems.
- Supported TANSACS in establishing and strengthening the DAPCUs in 29 A and B Districts
- Supported SACS in setting up the State Information Centre on HIV/AIDS, a repository of all HIV IEC materials produced in the state.
- Designed and conducted different communication campaigns to create awareness on HIV/AIDS and promote sustainable behavior change within the community.
- Supported the establishment of a knowledge management center in STRC.

- Trained 400 HCPs in private hospitals for ICTC services; 250 HCPs in private hospitals (community preferred HCPs); and 150 HCPs in the MHC program.

The project also organized special national and international expert lectures on a range of topics, including health economics, health care financing, interpretation of 2011 census data, and global OVC program experiences, which were well received by policymakers and program planners in the state.

Technical Support Units

Technical support units were established under NACP III to strengthen the planning, management, capacity building, and monitoring of the HIV/AIDS TI program at the state level. The mainstreaming of HIV/AIDS within different ministries was also a mandate of the TSUs. APAC supported two TSUs—one for Tamil Nadu and Pondicherry and one for Kerala. Both TSUs have played significant roles in scaling-up and strengthening HIV/AIDS programming.

TSU for Kerala

The TSU for Kerala has been in operation since December 2007. It has three team leaders—one each in the area of strategic planning, targeted interventions, and capacity building—and five program officers who work in separate regions and oversee 10 TI projects each and some support staff. Key contributions include the following:

- Ensured saturation of coverage for MARPs through evidence-based planning and rapid scale-up of TIs (from 36 to 52 in a short time).
- Built the capacity of the community to take ownership of programs; 35 CBOs were registered and 13 CBOs successfully manage TI projects.
- Supported DAPCUs and SACS in developing evidence-based annual action plans.
- Provided TS for revalidating the HRG population and for mapping the IDU population.
- Developed a map of the HIV burden at the state and *taluk* levels, which has helped prioritize activities in areas with higher HIV burden.
- Designed and conducted operational research in the areas of changing patterns of sex work in Kerala; the risk behavior of HIV-positive HRGs; the extent of condom use; and risk behavior among MARP through a polling booth study.
- Developed HIV/AIDS intervention strategy in prisons in 2009–2010. Facilitated capacity building of 210 prison officials on HIV-related issues and established six ICTCs in prisons.
- Provided TA to SACS to form PPPs and helped establish 25 ICTCs in the private sector.
- Initiated innovative "Know Your High Risk Group" campaign, which resulted in identifying MARPs who were accessing services as well as new entrants.
- Introduced site wise review and strategy formulation in TI projects, which resulted in enhanced service uptake throughout the state.

TSU for Tamil Nadu and Pondicherry

The TSU for Tamil Nadu and Pondicherry was established in December 2007. It has three team leaders—one each in the area of strategic planning, targeted interventions, and capacity building—and eight project officers for TIs. Key contributions include the following:

- Supported the scaling-up of TI programs in the state and saturated coverage among HRGs.
- Strengthened the reporting system and ensured 100% Computerized Management Information System (CMIS) reporting by TI NGOs and STI clinics.

- Created an epidemiological profile of HIV/AIDS at district and sub-district levels using data triangulation.
- Conducted revalidation of IDU mapping in Tamil Nadu.
- Facilitated the transition assessment of TI projects from donor agencies to the SACS.
- Standardized data collection tools across all SACS-supported TIs.
- Supported the rollout of the MHC program for FSWs and MSM.
- Facilitated mutual learning and knowledge sharing throughPE conventions and TESPIM.
- Built the capacity of STRCs and supported the rollout of training programs.
- Prepared NGO/CBO selection guidelines in line with NACO guidelines at the district level for state-specific initiatives.
- Established benchmarks for training quality control.
- Developed demonstration videos, using open source software to establish uniform understanding on indicators used in data sheets for training the outreach teams.
- Developed systems at the district level to strengthen cross referrals between various HIV/AIDS service providers.
- Developed a condom stock monitoring system at the TI level to ensure availability of adequate stock.

STRATEGIC INFORMATION MANAGEMENT UNIT

To maximize effective use of all available information, improve data quality, and implement evidence-based planning, APAC provided three consultants to assist SACS in establishing the Strategic Information Management Unit (SIMU). Key achievements of the SIMU include:

- Prepared epidemiological profiling for 32 districts at a granular level.
- Improved data quality and 100% reporting to NACO.
- Used mathematical modeling to prepare a report on the diffusion of the epidemic from a concentrated district to neighboring districts.
- Carried out data triangulation and situational analysis for evidence-based planning.
- Built the capacity of district program managers (DPM), district supervisors (DS), and M&E assistants on M&E tools and indicators.
- Prepared special reports on data analysis for evidence-based planning and programming, such as the "Positive Mothers Spouse Analysis" and "Prison Data Analysis" reports.
- Provided capacity building and technical support to carry out the HIV sentinel survey (ANC and HRG) and coordinated ANC and HRG surveillance activities
- Improved supply chain management of testing kits and medicines.

TECHNICAL SUPPORT TO TAMIL NADU STATE AIDS CONTROL SOCIETY TO STRENGTHEN THE DISTRICT AIDS PREVENTION CONTROL UNIT

Under Phase III of the NACP, decentralization of program management was an urgent goal. To stem the HIV/AIDS epidemic, it was recognized that efficient, close-to-the-ground management was needed to supplement governance from the national and state levels—as well as provide on-site monitoring, data collection, and management of day-to-day issues that could not effectively be dealt with at higher levels. At the local level, district officers could provide training to officials, medical staff, and others actively engaged with HRGs and PLWHA. Further, low

supply or stock-outs of condoms, testing kits, or and medicine can be quickly stocked confirmed and addressed, if not entirely avoided. In response and working closely with TANSACS and other stakeholders, APAC developed a state-level strategy to establish DAPCU in 29 districts in Tamil Nadu to help reach the goals of NACP III and further stem the epidemic.

> *"Technical support provided by APAC has enabled the faster rollout of DAPCUs in Tamil Nadu."*
>
> —Mr.Velmani, Joint Director (Finance), TANSACS, Nodal Officer, DAPCU

APAC began providing TS in September 2009. During the first year, the goal was to roll out, build capacity, and establish systems to operationalize the DAPCU. During the second year, the focus was modified to emphasize system strengthening, referrals, and linkages, micro-planning, supply chain management, complete ANC coverage, and financial monitoring. In short, APAC's principle forms of support for the DAPCU include the following elements:

- Development of administrative, financial and technical training modules;
- Team training of DAPCU staff;
- Robust systems for on-site mentorship and monitoring;
- District level micro-planning;
- Coordination between different HIV/AIDS programs and NRHM within the district for synergy and cross-referrals; and
- Coordination with district authorities to ensure ownership and transfer of social and welfare benefits to MARP and PLWHA.

Capacity-building Activities

APAC developed training modules to ensure the sustainability of the DAPCU program—and address staff turnover with an efficient, comprehensive training mechanism. The trainings included an orientation manual; an introduction training kit, which included a training manual, facilitators guide, and training handbook; a computer management information system (CMIS) training manual and facilitation guide; and a tool kit for the development of annual action plans. These diverse materials document the vital skills, knowledge base, and attitudes required to work within the DAPCU; provide the means for future trainings; and can be easily adapted for use in other states.

APAC also conducted extensive trainings to support the DAPCU. The project provided technical support for the orientation (December 2009) and introduction trainings (April2010) for the staff. Further support was provided for HR training to administrative and finance assistants (July 2010); CMIS training for DPMs, DSs, and M&E assistants (December 2010); and supply chain management training for DPM, DS, administrative, and finance assistants. APAC also supported DAPCU in developing district and village level plans through workshops and assistance in team building, data compilation, and analysis. Planning at the district and village levels required a degree of responsiveness to local conditions that was impossible at the state or national levels. In all, approximately 150 DAPCU staff, consisting of DPMs, DSs, Red Ribbon Club managers, administrators, finance assistants, M&E assistants, and office assistants were trained with the support of APAC.

System-strengthening Activities

Strengthening systems is central to all APAC initiatives—with the overall goal of creating organizations that are more consistent, flexible, sustainable and able to adapt to change such as unforeseen staffing shortages.

> *"I am a medical doctor with no administrative experience. The training and on-site mentorship provided by APAC has helped me to discharge my functions as a District Program Manager effectively."*
>
> —Dr. Stella Janet, DPM, Kanyakumari

- For administrative systems, APAC developed an HR manual and checklist to maintain standard operating procedures, combined with on-site mentoring and the development of uniform registers and databases.
- For financial management systems, APAC developed a financial manual and checklist to ensure uniformity of procedures, combined with standardized registers, on-site mentoring, an institutionalized voucher auditing system, and a system for tracking advances.
- For M&E systems, APAC developed a data validation system at the district level, as well as a state-level resource pool of M&E officers, on-site mentoring, line-listed database systems, and laptops for increased efficiency, monitoring, and communications.
- More generally, a system to strengthen referral linkages between TI/ICTC/RNTCP/STI/ ART and uptake of services was instituted—such that line listings were shared between ICTCs and ART centers. Furthermore, monthly coordination meetings allowed for referral uptake to be confirmed between these various linkages and to identify gaps. Booklets were distributed to all staff that clearly delineated roles and responsibilities. Along with a redressal system and regular meetings to ensure the smooth functioning of DAPCU, APAC also initiated an annual performance review for staff and a grading of DAPCU, based on key indicators.
- An extensive reporting system was also put into place—for recording monthly travel plans, activities, and feedback; as well as for submitting dashboard indicators to district collectors. Furthermore, DAPCU took responsibility for the stock and supply of HIV/AIDS-related medical kits at the district level, thereby decentralizing and more efficiently executing the task.

Impact

APAC'S TS to the TANSACS facilitated the efficient rollout of DAPCU in 29 A and B districts of Tamil Nadu. Capacity building of DAPCU staff, combined with institutional and system strengthening, will contribute to a more efficient, decentralized, and sustainable approach. Evidenced for this is found the increased numbers of referral and greater uptake among all linkages. APAC has produced an effective model with the potential for replication in other states and has helped the state move toward its goal of decentralization.

Lessons Learned

- Capacity building and system strengthening are vital components in any planned decentralization of HIV programming, ensuring consistent and high-quality provision of services without gaps.
- Decentralization leads to greater ownership at the grassroots level.
- Close collaboration with the government from the start has increased the likelihood of the sustainability of structures established at the district level.

- Skill-based trainings and on-site mentorship improved the performance of DAPCU as a whole and increased individual capacity of staff.

TECHNICAL ASSISTANCE TO TAMIL NADU HEALTH SYSTEMS PROJECT

In Phase III, APAC applied its experience and lessons learned from HIV/AIDS program implementation to contribute to the broader, state public health system. In its last two years, APAC significantly contributed to the strengthening of the TNHSP. Key contributions include the following:

- Trained 500 HCPs as TOTs for biomedical waste management and infection control (BMW & IC).
- Helped organize the International Conference on Health System Strengthening (ICONHSS).
- Helped establish the State Health Data Resource Centre (SHDRC); State Health Communication Resource Centre (SHCRC); and the State Health Research Resource Centre (SHRRC).
- Conducted an assessment of 11 medical college hospitals on BMW & IC and an assessment of 272 government hospitals.
- Supported a gender audit in public hospitals.

STATE HEALTH DATA RESOURCE CENTRE (SHDRC)

The Department of Health and Family Welfare has about 18 directors who are involved in managing health care activities for the state; each one is responsible for one or more aspect of health care. While these directors generate voluminous data, it is vertical in nature (i.e., within their respective departments) and not effectively utilized or shared among directors. Further, health information systems have not kept pace with changes—and have been more focused on data compilation. So, while a vibrant private sector, civil society and academia contribute enormously to health outcomes in the state, there is no institutional interface available to exchange information, knowledge, and feedback. Collective knowledge and action would mitigate many challenges and improve stagnated health outcomes. To better understand the health status of the population and important subgroups—for better health care management—it was important that all information be available and consolidated in one place, forming a comprehensive and integrated health profile of the state.

Recognizing this need, APAC partnered with the TNHSP to establish the State Health Data Resource Centre (SHDRC) in Tamil Nadu. The SHDRC, a first-of-its-kind initiative in the country, integrates information from 18 medical colleges, 41 medical colleges with attached hospitals, 29 district headquarter hospitals, 241 sub-district hospitals, 1,539 primary health centers, and 8,706 health sub-centers, as well as maternity homes, dispensaries, and health posts run by 151 municipalities and 10 municipal corporations.

The initiative's goal is to enhance coordination, decrease overlaps, improve efficiency and facilitate integration between health departments. The center will have a live register on health care staff at different facilities, commodities and other infrastructure details. It's also planned to make the health facility data available to the general population. SHDRC will develop software and establish institutional mechanisms to help the 18 health departments and their district bodies access and analyze relevant indicators, as well as analyze data through triangulation with different departments.

The Indian Council of Medical Research (ICMR) has formally approved the initiative and SHDRC is planned for January 2012.

APAC Support for Voluntary Health Services for State Health Data Resource Center

- Conceptualized SHDRC in collaboration with PD-TNHSP.
- Technical and financial support for rapid assessmentstudy of 18 directors and four districts with the help of professional IT consulting agency, CNSI (technical agency).
- Developedimplementation plan and operational manual to establish SHDRC—a blueprint for the government to usethe information for decision-making.
- Mentored TNHSP in advocating at the state and national levels to garner administrative and financial support from GOI to establish SHDRC in the state.
- Guided the process of convergence of RNTCP, HIV, and NRHM to ensure HIV-related data sharing and decision-making.

TECHNICAL ASSISTANCE TO CIVIL SOCIETY ORGANIZATIONS

Background

From its inception, APC has utilized a comprehensive capacity-building strategy, built on guiding principles that empower CSO partners to ensure sustainable interventions, improved quality services, and tangible health outcomes. These capacity-building approaches and methodologies have been replicated by other partners and projects, such as the BMGF and by the government at national and state levels.

In addition, APAC has introduced and demonstrated systems—such as the ESRM, PSV, NGO selection process, and financial system—with SACS for integration into TANSACS management. (TANSACS renamed the ESRM the Thematic Experience Sharing and Performance Improvement Meeting [TESPIM]).

Guiding Principles [BH]

- Aphilosophy that invests in partners to build a united team and ensure high-quality programs.
- A focus on capacity building for local institutions and individuals.
- Diverse support based on job needs, that evolved from training for PEs and retailers to developing systems for strengthening health provider skills and attitudes.
- A systematic approach that covers needs assessment, training and institutional support, and tracking change. Capacitybuilding and training were customized for each thematic intervention.
- Involvementof the community (target populations, health providers) in developing customized training.
- Flexibility to respond to emerging state and program needs.

APAC's comprehensive capacity-building approach used a range of methodologies, including training programs, mentoring on site, building up associations, and institutional, technical, and policy development support. It also featured on-site and structured training for NGO staff, based on agreements with partner NGOs on the timings and deliverables for staff training. Training for CSOs was customized for individual thematic interventions. In addition, APAC developed customized training modules for its interventions through a consultative process with the community.

APAC's training and TA was further reinforced by monitoring and TA mechanisms. These included PSVs; regular ESRMs for NGO representatives focused on particular thematic interventions; and cluster meetings, which brought together NGOs in particular geographic areas for idea and experience sharing, along with arranged visits for projects and NGOs for exposure to individual success stories and new ideas and models.

In Phase I (1997–2002), TA was institutionalized through a needs assessment, training modules, and follow-up monitoring visits. Partnerships were developed for on-going support as needed—including NIS SPARTA and the Center for Entrepreneurs (CED) for condom promotion; Gandhigram University for a TOT Center on Peer Education; and the South India AIDS Action Program and CMC Vellore for training on counseling, bioethics, and Epi Info software use. APAC set up a consultants' network of technical and management experts to provide on-site training and mentoring in the field, with its own system of mentoring and training for consultants.

In Phase II (2002–2007), the program expanded to identify a network of training and resource centers: five CETCs to train health providers; DCs to provide on-site training and mentoring for capacity building on targeted interventions; and, later a RTC on folk media.

In Phase III (2007–2012), APAC conducted regular training programs and introduced new ones on program management, advocacy, polling booth survey, resource mobilization, transition, and gender. Other initiatives included the following:

- **APAC Family Meet**. APAC introduced APAC family meet once a year to create a platform for interaction between VHS, APAC, and all partners. Here, APAC gets feedback from partners and shares its own expectations and plans.
- **Training on programs for HIV-positive and affected children**. APAC supported the Community Health Education Society (CHES) as a demonstration center on the OVC

program. The center organized six training programs for NGOs and CBOs already involved in health, care and support programs to enable them to integrate programs for HIV-positive and affected children.

- **Linkage between communities' preferred HCPs and NGOs**. APAC promoted the Nakshatra clinics and capacitated the HCPs. Systematic efforts have been made to ensure links between NGOs and community preferred clinics with monitoring.
- **Mentoring and joint visits to NGOs**. APAC transitioned all NGOs to CBOs in a phased manner. With the TSU and SACS, APAC developed a joint mentoring plan for six months to ensure implementation uniformity and to track post-transition indicators.
- **Exposure visits for NGO directors and project teams**. APAC organized a five-day exposure visit for each NGO team to visit best interventions in other states, with the guidance of consultants and technical officers.
- **Community-based organization formation**. Each NGO undertook initiatives to form CBOs for transitioning from NGOs to CBOs. The CBOs were capacitated on community mobilization, good governance, etc.

In all three phases, NGO partners involved in TI—irrespective of the theme—came together in clusters (seven or eight districts) to discuss coordination and how to maximize synergies and impact. This opportunity was also used to share data (BSS, community prevalence study data, etc.) and develop or modify action plans to meet challenges.

With financial assistance from USAID, APAC initially invested in development of its own staff, partners, and consultants through a comprehensive capacity-building approach that included training, mentoring, joint planning and field visits, exposure visits, and participation in regional, national, and international conferences.

APAC also recognized early that it was necessary to extend capacity development beyond its own staff and consultants to provide TA all the organizations that sought its help. To this end, APAC developed and employed a pool of experts who could be utilized locally and nationally. It also worked to build capacity of 35 research and training institutions that had both a mandate from the GOI and the potential to serve a larger number of organizations These institutions served as multipliers of APAC's high-quality TA effort and are recognized by NACO/SACS as resources in the continued fight against HIV/AIDS.

Achievements

- APAC built the technical and management capacity of its partner NGOs.
- The "APAC NGO model" has set an important standard for productive partnerships with private sector institutions.
- APAC has established excellent, supportive networks among its NGOs at thematic and cluster levels. As they have matured, APAC NGOs have also developed effective working relationships with non-project NGOs and the public sector. The NGOs have also fostered the development of community-level CBOs.

For examples of APAC's effective delivery of TA, see "Case Study 4: Empowering NGOs through Capacity Building," "Case Study 5: Empowering Health Care Providers through Capacity Building," and "Case Study 6: Capacity Building for Condom Retailers for Condom Retailers" in Appendix E.

LESSONS LEARNED

The key lessons learned include:

- **The establishment of resource centers, field labs, and demonstration centers led to systematic transfer of knowledge.** Resource centers and field labs have provided the opportunity to offer participants a structured training program focused on different aspects of the program, allowing them to practice learning in the field. It significantly improved the impact of the training program.
- **Emphasis on strengthening local institutions and individuals as TA providers.** Building capacity of local institutions and individuals is the most cost-effective and sustainable way to ensure effective and efficient program delivery. It creates a pool of trained manpower and support institutions to take up community development challenges and programs..
- **Investing in APAC staff as TA providers built in-house capacity and was cost efficient.** Using the same staff for providing TA was cost-effective and capitalized on their skills, which were built over time. It also supported staff in multi-tasking and broadened their perspective.
- **Joint planning, design, implementation, and evaluation of TA programs fostered ownership and scope for mid-course changes.** Joint planning and monitoring of TA activities facilitated ownership by local organizations. This also made the process participatory and ensured that partner institutions' concerns/needs were met.
- **Demonstration of evidence-based and successful practices/approaches led to replication.** Demonstration of evidence-based, successful initiatives helped APAC advocate for national and state governments to replicate the initiatives in their domain. It also convinced other organizations to adopt the practices and approaches.

Recommendations

Key recommendations include the following:

- **Capitalize on APAC's learning and experience.** Over the life of the project, APAC has developed a pool of experts who have experience working with government and CSOs. There is need to ensure that this resource pool doesn't get lost. In some form, they should continue to support government and CSOs in improving the effectiveness and efficiency of their work.
- **Provide support for sustainable innovative models/setups.** APAC initiated several new initiatives (SHCRC, SHRRC and SHDRC), which are still in a nascent stage. There is need to support these initiatives until they are fully functional, so that sustainability is ensured.
- **Sustain the TSUs.** Technical support units have played a key role in strengthening the program and providing full coverage. At this critical juncture, when there will be an increase in SACS's workload due to the transitioning of TIs, it is critical that these TSUs continue to provide support to SACS.

> *"TANSACS has adopted the ESRM and PSV for effective monitoring and capacity building of NGOs. Similarly, the NGO selection process was very much adopted by TANSACS to select suitable NGOs by adhering to stringent technical and financial guidelines and a transparent selection process. This has also helped in avoiding unnecessary recommendations."*
>
> —Mr.Deenabandhu, IAS, former Project Director, TANSACS

APAC-VHS PRIVATE SECTOR ENGAGEMENT AND COLLABORATION

From the start, APAC developed unique models of private sector engagement to address the challenges of reducing HIV/AIDS prevalence in Tamil Nadu. The initial impetus for private sector engagement was functionality—specifically, the need to increase access to quality HIV/AIDS prevention and care services for MARP (particularly access to condoms and STI treatment). The two main avenues used were partnership with the corporate sector (through the provision of HIV/AIDS programs or a corporate social responsibility approach) and partnership with the private health sector, which accounts for approximately 80% of health services in India.

The guiding principles that emerged over time and shapedprivate sector engagement included:

- Joint planning;
- A transparent process of governance to protect the contributions and benefits of all partners;
- Strategic partnerships with corporations that focus on long-term commitments;
- Capacity building of private sector partners;
- Multi-pronged strategic approaches;
- A clear system and legal basis for engaging private sector partners;
- A new network model for CSM to link manufacturers with NGO partners; and
- A model for mutual leveraging based on the contribution of key resource inputs from all partners (see "Case Study 8: A Partnership for Protection: Offering ICTS to Truckers and FSWs" in Appendix E.)

Models for engaging the private health sector were strengthened by clearly defining fiscal, commodity, training, and human resource contributions and by requiring a universal data collection process. In the later phases of the project, the innovative partnership with Tata Industries to create a toll-free helpline on HIV/AIDS was based on these principles of resource leveraging.

These innovative approaches will contribute to a white paper on PPP within the health sector that is currently being developed by APAC in collaboration with the Indian Institute of Technology and MSG Strategic Consulting Pvt. Ltd. The white paper will review the opportunities and challenges for PPP in health programs; analyze current national and state-level PPP policies and key lessons from initiatives; and make recommendations for scaling-up sustainable PPPs in the health sector.

BEST PRACTICES/LESSONS LEARNED

- Involving the community in selecting private-sector health providers increases the number of clients seeking quality services.
- Enhancing access to stigma-free quality care requires building compliance with national guidelines by private sector providers.
- Building a reliable supply chain of medical kits from government makes treatment affordable and sustainable.
- Creating unique health cards for clients ensured confidentiality and appropriate care.
- Creating strong documentation and reporting systems offers evidence-based data to improve the overall national AIDS program.

Nakshatra: A Public-Private Partnership Model for Future Scale-up

In 2008, APAC and VHS piloted the Nakshatra Project to facilitate partnerships between private sector providers and the government in order to (1) provide quality STI services for HRGs; and (2) demonstrate a viable and scalable PPP model to address the treatment needs of clients who seek STI services in the private sector. (See "Case Study 7: "Parameswari's Story: 'They Really Take Care of Us" in Appendix E.) The project differs from earlier initiatives (such as the BMGF's Avahan Project) in that the nature of PPP helps make services affordable and sustainable, with the STI kits supplied by the government. For the pilot, 110 clinics and hospitals in seven A districts of Tamil Nadu were selected and were branded with the label "Nakshatra."

Figure 17. Partnership Leveraging Equation

TANSACS	IRT MEDICAL PERUNDURAI COLLEGE HOSPITAL	PRIVATE CLINICS and HOSPITALS	SAATHI	APAC
• Implements NACP-III • Provides STI kits • Reports Nakshatra data to National program • Provides state-level guidance and interfaces with government HIV programs	• Training partner for training Nakshatra doctors, nurses, and other paramedicals, as well as experts for clinical mentorship visits	• Includes clinical facilities and support staff **NGOS & CBOs** • Funded by APAC-VHS to mobilize MARP and refer them to the Nakshatra clinics and hospitals.	• Technical agency that carries out training; monthly supportive monitoring visits; coordination of STI kit supply; resource mobilization; technical updates and collation of monthly data; and district-level networking	• Subsidizes clinic visits by MARPS • Provides financial support to the technical agency for capacity-building and system-strengthening activities.

Strategic Framework

- Focus on incubating stigma-free care to MARP, many of whom are marginalized because of their behavior, sexuality, or gender nonconformity.
- Foster client confidentiality.
- Support provision of treatment and care as part of standardized guidelines, as developed by NACO.
- Document and report on cases treated by the private sector that were sent to the government to enable program monitoring at state and country level.

Objectives

- To increase demand for care, support, and treatment services by motivating MARP—and the general population—to get tested and know their HIV status.
- To improve health-seeking behaviors of PLWHA and MARP, with a focus on positive prevention.
- To build the capacity of selected private practitioners on clinical care for
- PLWHA and MARP in each of the implementation districts.
- To increase access to comprehensive care services for PLWHA and MARP
- through a network of private HCPs at a subsidized cost.
- To provide psychosocial support and create an enabling environment for PLWHA, MARP, and their family members.
- To strengthen the referral mechanism between service providers in the private and public sectors.
- To create continuum-of-care services for PLWHA and MARP that are free of stigma and discrimination.
- To establish linkages with NGOs, FBOs, and CBOs for an effective continuum of care.

Project Implementation

- This project identified community-preferred providers and provided training on STI/ HIV clinical care and on HIV/AIDS. It also ensured linkages with ICTC services. Starting in October 2010, services were made available at no cost by the project.

Outcomes

- From May 2009 to September 2010, Nakshatra facilities treated 3,653 STIs for FSWs; 1,059 STIs for MSM; and 7 STIs for transgender clients.
- The total number of HRG members who received services for the first time at Nakshatra facilities was 3,873, with 846 (22%) coming in for follow-up treatment. This comprises 62% of the HRG population (estimated at 6,200) living in the focal districts who had expressed willingness to pay 30 INR for STI services. (This was shown in an earlier assessment by APAC-VHS.)
- From October 2010 to September 2011, 6,982 individuals sought treatment, of which 4,392 were follow-up cases.
- MARP are confident accessing STI and other clinical services from these branded "Nakshatra doctors," as shown in an assessment study and the increase in clinics' client loads.
- Private providers are starting to adhere to uniform STI treatment guidelines. Supply of color-coded STI kits and a simplified documentation format have helped private providers understand the need to report data to the national program.
- An increase in periodic medical checkups (from 5% to 20%) has resulted in a decline of symptomatic STI cases.

Social Marketing of Condoms Model

The strategic framework for APAC's SMC modelhad three key strategic goals:

- Increase both accessibility and sale of condoms by strengthening supply and demand through the introduction of socially marketed condoms.
- Enable interface between NGO networks and major condom manufacturers.
- Introduce new concepts in condom promotion.

To achieve its goals, APAC invested in strong partnership networks with the private sector, which included selected major condom manufacturing companies, private sector retailers, advertising agencies, and NGOs. The program had five major operational components: private sector collaboration; training retailers; a generic condom promotion campaign; social and test marketing through NGOs; and quality testing.

From the outset, APAC leadership was fully committed to developing a high level of buy-in and commitment from the major condom manufacturers. The private sector selection process included five key stages: (1) a scope of work along with request for proposals (RFPs) sent to condom manufacturers; (2) review of proposals by an expert team; (3) presentation to the expert team by the condom manufacturers; (4) modification of a proposal based on expert team recommendations; and (5) the award of a contract.

Based on this selection process, an expert committee of external marketing experts and USAID and APAC officials reviewed the proposals and contracted JK Ansell/Raymond Group, Hindustan Latex Ltd. to operate in the entire state (1996–1999). In the latter years, the state was segmented into three regional clusters; and each manufacturer was supported in meeting the needs of one cluster. TTK LIG was contracted during this phase to service one regional cluster. Financial support to the manufacturers was reduced in a phased manner to ensure that the operations were sustainable.

An innovation of the SMC model was creating an environment that not only built strong buy-in from major manufacturers, but also developed a new network model whereby manufacturers worked closely with NGO partners and traditional and non-traditional private sector retailers. Prior to this partnership, companies such as JK Ansell had never worked with the NGO community to promote its condom brand, as well as map out new condom market penetration points within non-traditional retail outlets in semi-urban and rural areas. The SMC network model included the following features: open and regular communication between partners; timely collection, analysis and feedback of field data; use of field data by partners to make improvements in condom supply and distribution to retailers; building on the resources of multiple partners to increase impact in supply, distribution and accessibility of condoms; opportunities for partners to be innovative.

> *"The partnership was a unique one for our company as it gave us an opportunity to develop a better understanding of condom market penetration in non-traditional retail outlets in peri-urban and rural areas. We were also able to extend our reach and build a stronger distribution network with new private retailers and the NGO community. APAC was a great partner to be associated with!"*
>
> —Mr. R. Mohan, Director and Business Head, JK Ansell/Raymond Group

The SMC strategic framework focused on the following key areas of private sector collaboration with condom manufacturers:

- Increased distribution and sale of condoms;
- Promotion of linkages with NGO partners;
- Support for operations;
- Support for incremental sales and new outlets;

- Support for manpower and promotion;
- Periodic monitoring by external consultants, with support based on reported reliability rates;
- Service for NGO areas and certification by NGOs;
- Introduction of single piece condoms; and
- Strategies based on market conditions and need.

Figure 18. Partnership Leveraging Equation for the PPP

CONDOM MANUFACTURERS	APAC	NGO
Advertised and promoted products; invested in van operations. Allocated sales representatives to interface with NGO network and ensure timely supply of condom products in NGO intervention areas. Top management staff time. JKAL supplied additional manpower; invested in trade incentives and van operations to increase coverage; offered stock incentives to encourage partnerships and field force incentives; conducted regular training program; printed collaterals (retailer cards, other materials etc.).	Recruited additional sales force to cover non-chemist outlets. Trained sales teams. Operated a trade scheme to motivate retailers to increase quantity of purchase and display condoms conspicuously at outlets. Implemented schemes for targeting end-users. Serviced interior markets through van and automobiles. Publicized the product at retail oultets and via outdoor media.	Offered capacity building of retailers. Mapped out new retailer networks. Monitored condom distribution patterns using Permananet Journey Cycle. Monitored performance of sales representatives in collaboraton with condom manufacturers. Monthly performance reporting consolidated by JK Ansell/HLL and submitted to APAC for reimbursement.

The leveraging equation refers to the key resource inputs agreed upon by each partner in the PPP.

Another key feature of the SMC Model was the governance structure of the PPP. A formal contractual agreement guided the partnership, providing clarity of roles and responsibilities for each partner; a performance-based cost reimbursement system for condom supply distribution; specific timelines for achieving results; data collection, analysis and feedback systems; and accountability systems. A partnership management team was established to support strategic and programmatic guidance throughout the implementation process and ensure high levels of governance and accountability. The close collaboration between the APAC/VHS management committee and the condom manufacturers fostered trust and confidence in maintaining the partnership, setting higher performance standards for companies and addressing challenges collectively.

The Impact of Collaboration with the Private Sector

APAC launched a generic condom advertising campaign in 1997, which created healthy competition among manufacturers and encouraged companies to invest more in advertising and promotions; JK Ansell supported 60% of the advertising budget. The generic campaign was followed by manufacturers' advertising campaigns, which, combined with the robust NGO-manufacturers' supply side collaboration, resulted in a significant increase in condom retailer

outlets (from 17,600 to 35,400) and growth in condom sales (from 17.8 million to 31.3 million). The overall condom market doubled.

It should be noted that market growth stagnated after 1998; and it was assumed that this was due to complacency because of lack of competition. In response, APAC revised its strategy by segmenting the state into three zones and allocating each zone to three different manufacturers for promotion and distribution of their brands. However, this did not lead to further growth in the market. Also noted, 80% of condom sales were registered through traditional outlets (pharmacies and drugstores). Ultimately, the market stagnation was contributed to a target-oriented approach that increased outlets, but did not result in sustained sales by those outlets.

BEST PRACTICES/LESSONS LEARNED

- Through a generic advertising campaign, APAC created healthy competition between condom manufacturers, which encouraged increased financial investments from each company.
- Building a robust NGO-manufacturer partnership ensured regular servicing at NGO intervention sites and sustained supply-side distribution.
- Private-sector retailers became more customer-friendly following NIS capacity building.
- NGOs were enabled to provide technical training for retailers and to monitor condom manufacturer service delivery to boost supply and demand (from MARP).
- NGOs played a significant role in motivating retail outlets and promoting linkages with sellers and condom manufacturers, with training.
- Utilizing a performance-based cost reimbursement system was highly effective in improving condom supply side distribution.
- Creating a healthy, competitive environment between advertising agencies led to innovations in IEC campaigns, new social marketing strategies, and products.
- The target-oriented approach of increasing condom outlets did not result in sustained sales by them; this was due to lack of follow-up by manufacturers with the new outlets opened.

Hello+ Model

In its quest to launch an HIV/AIDS helpline, APAC created a unique model of bringing together technical expertise with public, private, and civil society organizations. The helpline, Hello+, involved TATA Business Service Solutions (TBSS), with expertise as a call center service provider; APAC-VHS, with expertise in HIV/AIDS program management; stakeholders, through the participation of networks; and TANSACS, to improve sustainability and streamlining. A key success of APAC-VHS was to negotiate additional leveraging of resources from TBSS, which agreed to match the investment of NACO of USD $45,000 as part of its commitment to transfer ownership of Hello+ to NACO.

Figure 19. Partnership Leveraging Equation for Hello+

Overall, APAC-VHS designed and developed a unique PPP process model, described in the text box.

Best Practices/Lessons Learned

- Early in partnership building, the networking of senior company corporate leadership and government ensured sustained partner commitment and buy-in to leverage additional resources over the longer term.
- APAC was key in convincing corporations (i.e., TATA) to increase leveraging to match government funding—this was critical to ensuring dedicated resources for a smooth transition process.

TANSACS	TBSS	APAC
• Help create an information directory with all services schemes provided by the government for PLHIVs • Promote the helpline through IEC materials/campaign	• Software development and maintenance • Soft skills and on-the-job training • Call charge subsidy by 50% • Day-to-day management • Counselors on TBSS roll • Top management time	• Training and mentoring • Guidelines and protocols • Monitoring and quality assurance • Database of service providers • Targeted promotion • Resources

PROCESS I: PARTNERSHIP EXPLORATION

- Needs assessment
- Market analysis
- Participatory consultation with community
- Finalization of contract document/bidding process
- Selection of partner

PROCESS II: PARTNERSHIP BUILDING

- Negotiation with partner
- Perspective building of private sector partner on resource- and risk-sharing
- Facilitate development of product
- Pilot test the product
- Launch and implement operation

PROCESS III: PARTNERSHIP SCALE-UP, LEVERAGE AND TRANSFER

- Scale-up services
- Evaluation
- Documentation and dissemination for PAN INDIA Helpline with NACO
- Transfer the helpline with appropriate cost sharing, leveraging of resources, perspective-building of a private player
- Transfer with support and mentoring

- The use of assessments in a timely manner improved the overall quality of counseling services and expanded a new range of information services—all tied to evidence-based findings of new client needs.
- The encouragement of innovations in PPPs to develop new products—such as new software CRM or the use of mystery clients to monitor the quality of counseling services.

WHITE PAPER ON PUBLIC-PRIVATE PARTNERSHIPS

During Phase III, APAC began exploratory discussions with the Indian Institute of Technology (IIT) to develop a white paper on PPPs within the health sector across India. With 17 years of experience in building, maintaining and transitioning a number of PPPs to the Tamil Nadu Government, this was an excellent opportunity for APAC to exchange knowledge on the types of PPPs that may be replicated in other states. APAC-VHS is currently working with IIT and MSG Strategic Consulting Pvt. Ltd. to develop this paper on PPP opportunities and challenges, which will provide an analysis of existing national- and state-level PPP policies and governance structures, key lessons from PPP initiatives in health programs, and an overview of future opportunities in the sector.

Best Practices/Lessons Learned

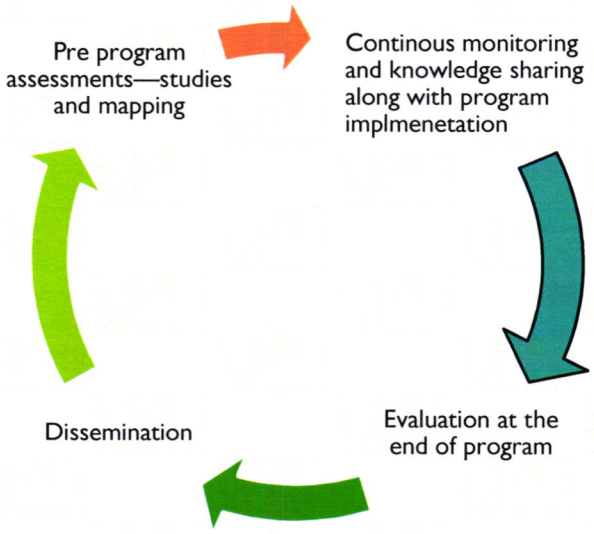
- Involving the community in the selection of private-sector health providers stimulates the demand-side for clients seeking quality services.
- Enhancing access to stigma-free quality care requires building compliance with national guidelines by private sector providers.
- Building a reliable supply chain of medical kits from government makes treatment affordable and sustainable.
- Creating of unique health cards for clients ensures confidentiality and appropriate care.
- Instituting strong documentation and reporting systems offers evidence-based data to improve the overall National AIDS program.

VI. IMPROVING QUALITY, EVIDENCE GENERATION, AND SHARED LEARNING

APAC'S RESEARCH AGENDA AND PROCESS

From the start, APAC focused on generating high-quality evidence for program design and implementation. APAC's dynamic, flexible research agenda shed light on emerging challenges and developed needs-based responses. This, combined with a responsive M&E system, as detailed later in this section, has resulted in effective programming that has significantly contributed to reversing the state's HIV/AIDS epidemic and strengthening the broader public health system.

Figure 20. APAC's Needs-based Research Process



Under APAC, some research, including BSS, was planned in advance and carried out periodically, while other studies were in response to programmatic and community needs, like the "Willingness to Pay" study among PLWHA. Demand for research also came from stakeholders, such as the government and CSOs. The research process involved external consultants and organizations, which helped APAC capitalize on outside technical skills and knowledge. Another key aspect has been the focus on capacity building and training of team and community members. APAC ensures that research findings are disseminated to stakeholders, partners, and program teams as well as broadly shared via Web sites, journals, and conference presentations.

To strengthen government SI/M&E systems, APAC shared its findings, experiences, and skills in multiple ways with the government at state and national levels. This is a key APAC contribution—supporting the state in developing evidence-based programming through data sharing.[10]

To support information sharing and the development of evidence-based programming, APAC's research design built in a method to ensure that its findings were properly disseminated. Several findings have resulted in significant impact: a facility assessment improved health infrastructure at

[10]Prior to APAC, there was a lack of data to support effective program design at both the state and national levels, with the first national surveillance conducted in 1998, and only at a limited number of sites.

the site; BSS findings resulted in an increased focus on MARP-related issues; and innovative studies such as the "Willingness to Pay" study among PLWHA contributed to the design of specific PPP initiatives. The BSS and other research supported SACS in evidence-based planning at the state level.

To support sustainability, APAC assigned staff to the SIMU in SACS to build capacity for data analysis and improve data quality. SACS adopted APAC's ESRM system for experience sharing. APAC shared its expertise with NACO in different ways. It assigned NACO staff to support the SIMS development and rollout. APAC conducted data triangulation exercises for TN, UP, and Uttrakhand that supported evidence-based planning in the states. The resulting improvements in data quality and usage among SACS and NACO have been institutionalized as systems in these organizations, supporting sustainability.

RESEARCH USE FOR PROGRAM DESIGN AND IMPLEMENTATION

APAC's research system was well integrated into its program life cycle. The project conducted pre-assessment studies and mapping to estimate target group populations, understand behavior, and develop baselines. This contributed to evidence-based programs and appropriate strategies for sustainable behavior change. APAC disseminates its learning to wider audiences by sharing reports and case studies, ; organizing workshops; and demonstrating best practices at field labs, where visitors learn through hands-on experience.

USE OF BSS FOR EVIDENCE-BASED PLANNING

BSS is a useful tool to track the behavior of communities over time, providing a baseline to assess progress and guide development of strategies to support sustainable behavior change among target groups. Since the first BSS was conducted in 1996, it has been conducted annually and then every two years. To date, 12 BSS waves have been completed in urban areas and six waves in rural areas; seven waves were also carried out in the adjacent state of Pondiucherry. A baseline BSS was done in 2009 in the seven APAC Intensive Intervention Districts, as well as one among PLWHA9.

The nature of BSS is dynamic, with new indicators added in 2002 in response to emerging data needs. The major indicators measured include knowledge, sexual behavior, injection drug use behavior, health seeking behavior, risk perception, voluntary HIV testing, stigma and discrimination, and exposure to intervention.

The BSS is carried out for FSWs, truckers and their assistants, male STI patients, male and female factory workers, MSM, male youth in slums, IDUs, male and female migrant workers, AravaniPengal, and male and female students. Consistent BSS has helped in monitoring and evaluating interventions; design and improve programs; set an agenda for future research; and make cross-country/cross-state comparisons.

OVERVIEW OF APAC'S M&E SYSTEM

APAC has integrated M&E into all stages of program implementation and developed a system to ensure regular feedback on program performance. Timely evaluation of initiatives allows APAC to understand program impact and identify what has worked and what has not, using the information to enhance impact.

APAC's monitoring system employs both quantitative and qualitative methods to explore all aspects of programs, along with regular capacity building and supervision. NGOs submit monthly reports with information on critical indicators. The report is then analyzed to identify gaps in coverage and indicators of progress toward targets. The APAC team visits project sites on a

regular basis to advise and assist implementing partners. Regular data quality audits verify data accuracy. NGOs upload data to NACO's CMIS, while APAC forwards a consolidated report to USAID in the PEPFAR reporting format.

M&E'S IMPACT ON PROGRAM DESIGN AND IMPLEMENTATION

Like its research system, APAC's M&E and data quality assurance (DQA) systems were integrated into the life of its programs. In-program monitoring and assessments ensured that programs were on track; collected evidence to understand the changes required; and supported mid-course corrections. Specific activities included tracking of data from the field level; review of the NGO's program; and operational research to answer unresolved questions. These activities were designed and implemented to meet programmatic needs, identify emerging challenges, and facilitate learning at all levels. The evaluation at the end of program measured intervention impact and achievements and provided direction for future programming.

DATA QUALITY ASSURANCE SYSTEM

Good quality data is critical for effective decision-making and program design. Attention to data quality improves program performance and resource management. In Phase III, APAC brought in a DQA system to improve data quality. The key activities were the following:

- **Standardization of formats.** A standardized format lends clarity and consistency to the data, as opposed to multiple formats, which can cause confusion. Thus, the different indicators used in monitoring from APAC, NACO and PEPFAR were integrated into one uniform reporting system.
- **Integration of DQS in the MIS of NGO/CBO partners.** To make data quality testing an integral part of the M&E system, it was integrated in the MIS and the reporting system. Data quality checks were introduced at each stage of data collection and entry. Both DPOs and PCs were trained in data quality process and minimum requirements for checking were fixed. A PC accompanied the ORWs in the field for at least two or three days and verified at least 10% of the reported numbers. Data is also verified at the NGO and DPO levels before sending to APAC. At APAC, TOs triangulate different indicators and ensure the data's correctness. Timely feedback is provided to the partner organizations on data quality and accuracy.

Data Quality Audits

To assess improvements made by the DQA system and suggest further improvements, APAC started a data quality audit about two years ago. The first audit was conducted between March and April 2009 for data reported from October 2007 to September 2008. APAC selected qualified external consultants and provided them orientation on audit tools. The consultants then visited NGOs for two days; carried out audits in a participatory manner; and submitted the information to APAC. The reports showed some gaps and errors in data collection and entry. APAC provided feedback to the NGOs, along with mentoring to strengthen the system. The second round of audits was conducted in 2010 for data collected between October 2008 and September 2009. It showed significant improvement in the data collected by the NGOs. In two rounds of data audits, consistent accuracy (90% or more) has been observed in key indicators. Overall, the adoption of a DQA system resulted in better data quality; faster accessibility of data; easier tracking of performance; and improvement of overall program management.

RESEARCH AND M&E: GUIDING PRINCIPLES OF BOTH SYSTEMS

The guiding principles of APAC's research planning and M&E systems include the following:

- **A focus on capacity building**. From the start, APAC focused on building the capacity of community, staff and NGOs to implement M&E systems and use the findings for program planning and monitoring. APAC had a well-designed training plan for staff that covered the different processes involved, including on-site support on M&E tool use and explanation on the finer points of the M&E system.
- **A focus on data quality.** Another key principle was the focus on maintaining and improving quality of data at all levels. In Phase II, APAC brought in a DQA system; in Phase III, it introduced internal data quality audits to evaluate the quality of field data collected and identify areas for improvement.
- **A well-planned system**. The process of data collection at each level was well-defined, along with the monitoring and capacity-building plan. External organizations and consultants supported these processes.
- **A focus on qualitative inputs.** APAC understands the need for qualitative inputs and focuses on building systems that support this need. Through experience sharing and review meetings, APAC provided a platform to NGOs to share their achievements and challenges and facilitate mutual learning. Participatory site visits provide focused inputs to the NGOs by qualified experts.
- **Involvement of the community.** The focus on community involvement and capacity building increased local appreciation of the importance of data collection and and facilitated the collection of high-quality data for program planning, monitoring, and decision-making. It has provided the NGOs with a pool of community members trained in M&E who can be used in other initiatives.
- **Valuing adaptability and innovations**. Ability to rapidly adapt with changing requirements and innovative new tools/techniques for strengthening the system was hallmark of the M&E and research system. APAC was successful in aligning its system with the PEPFAR's and NACO's changing requirements. Although the project needed to meet multiple requirements, APAC managed to keep its system simple and ensured that NGOs were provided capacity-building to implement the modified system. APAC adapted technologies and developed systems to strengthen quantitative and qualitative monitoring. APAC started using computers early on in its projects to speed data collection and analysis processes; it also developed a GIS-based system for spatial analysis. APAC developed systems like ESRM and PSV to strengthen qualitative monitoring and providing capacity-building support.

Supporting the state in improving health infrastructure

APAC conducted two assessments of various health facilities for TNHSP. The first was brief and conducted in a few select settings. The findings informed a new TNHSP proposal for funding to improve the health infrastructure in the state. In response, the World Bank provided more than 500 crore to TNHSP.

The second assessment examined 272 government hospitals to provide a detailed evaluation of health facilities available. The study showed the significant gaps in the facilities available at government hospitals. APAC shared the findings with Health Secretary, TN and PD, TNHSP. Post dissemination, TNHSP addressed the gaps detailed in the findings. Progress in addressing these gaps is monitored regularly during meetings of concerned officials.

RESEARCH AND M&E: KEY ACHIEVEMENTS

Key achievements include:

- **Effective program design and implementation.** APAC's M&E and research system have contributed to effective and efficient program design and implementation, which has contained the HIV/AIDS epidemic while supporting positive changes in HIV-AIDS-related attitudes and behavior in Tamil Nadu.
- **Production of high-quality data.** The two rounds of data quality audits show more than 90% consistency on key indicators. This was a result of APAC's continuous focus on improving quality.
- **Understanding emerging challenges and developing innovative strategies.** APAC's flexible and diverse research agenda provided a foundation for understanding emerging challenges and changing community needs. APAC's research contributed to development of innovative programs, such as PPPs for providing STI services and a program for cinema artists.
- **Support for developing a state-wide response.** By sharing its research findings, APAC assisted TNSACS in understanding the changing nature of the HIV/AIDS epidemic and developing an effective state-wide response.
- **Creating a pool of trained human resources**. At the time of the writing of this report, APAC has trained more than 5,000 community members and several NGOs in conducting research, collecting data, and strengthening M&E systems.

RESEARCH AND M&E: LESSONS LEARNED

- **Plan M&E as an integral part of program design**. This ensures that monitoring is an integral part of the program; indicators are well-designed; and the baseline is generated. It also helps to develop crucial indicators to track progress.
- **Integrate a DQ system with the M&E system.** Data quality must be designed as part of the data production process, not added later. Data quality improvement depends on providing continuous and timely feedback.
- **Focus on quantitative *and* qualitative data**. This is required for an effective and efficient program. While quantitative indicators help track program progress, qualitative indicators provide better information about the impact of the program on the community and key areas for improvement. It also facilitates knowledge sharing and mutual learning.
- Build staff and NGO capacity to participate actively and use data for program management. All staff involved in M&E and research must be well-trained on the tools and provided with support. Using technology makes systems more robust and efficient, improves access to real-time data,facilitates monitoring reduces system monitoring costs, and helps reduce data duplication and overlap.
- **Build partnerships with research institutions, NGOs, and government.** Partnerships help capitalize on available human resources and technical knowledge and improve work quality and effectiveness.

VII. TRANSITION FROM APAC TO SACS

GUIDING PRINCIPLES

At the start of the transition process, NACO, SACS, APAC and CSOs agreed on guiding principles and processes, including these key points:

- Development of a transparent road map, with buy-in from key stakeholders at the state, district, and national levels.
- Establishment of a Transition Coordination Unit (TCU) to guide the process and ensure coordinated planning and implementation.
- Adherence to NACO guidelines for staff structure, financial allocations, systems of capacity building, and M&E.
- Pre- and post-transition mentoring from APAC to NACO/SACS to ensure continuity and sustained performance.
- NGO staff who assumed responsibility for the interventions are working in partnership with the government on implementation.

BACKGROUND

By September 30, 2011, APAC-VHS had successfully transitioned all of its 29 interventions in the states of Tamil Nadu and Puducherry to the respective SACS. The SACS have started funding these projects with TSU and SACS jointly monitoring activities.

A joint consultative meeting was held between TANSACS, APAC/VHS, USAID/India, and Puducherry AIDS Control Society (PACS). In the meeting, they formed the TCU (see Table 3) to address technical issues involved in transition and to establish a road map to prepare stakeholders for inevitable challenges that come with the process.

A transition, like any project, needs careful planning and management. The TCU met frequently to develop and manage a transition action plan and process that included pre-transition, transition, and post-transition.

To ensure a smooth transition and reduce the possibility of service gaps, APAC worked in partnership with NACO, SACs, and NGOs to implement the road map within the NACP III framework. This was accomplished in a transparent, systematic, and phased manner to support the sustainability of project activities after USAID/India's funding ends.

Table 3. Transition Coordination Unit Composition

Position in the Core Team	Name and Designation of Members	Organization
Advisors	Project Director	TANSACS
	Project Director	Transitioning Organizations
Members	JD(F)	TANSACS
	JD-TI	TANSACS
	TL–TI	APAC
	Senior Staff	Transitioning Organization
	Senior Staff	Transitioning Organization
External Member	Consultant	Consultant
Senior Staff of Transitioning Organization would serve as convener for the Technical Coordination Unit		

In conjunction with its partners, APAC developed and disseminated guidelines in the form of a road map for transitioning TIs, which was used by each of the partners to operationalize the transition in a phased manner. NACO-approved tools for assessment were used to assess NGOs; while APAC and TANSACS provided joint planning, monitoring, and mentoring visits.

Figure 21 provides a detailed explanation of the transition process and its three phases, during which APAC provided intensive support to the NGOs.

Figure 21. A Phased Approach to Transition: Key Factors for Success

Pre-Transition

- Develop consensus on a timeline, process, and interventions to be transitioned.
- Allocate budget in an annual action plan to support the transition.
- Form a TCU to oversee the transition.
- Share NGO quantitative and qualitative reports with SACS.
- Familiarize NGOs on NACO's assessment tool and process for assessments.
- Familiarize consultants on APAC's systems and intervention packages.

Transition

- Form an assessment team consisting of a medical doctor, social scientist, and auditor as external consultants; APAC and SACS representatives serve as observers.
- Conduct a three-day assessment: review of records and documents;interaction with NGO directors, staff, community health educators (CHE), community members, secondary stakeholders and health care providers; field visits to understand the effectiveness of the interventions.
- Submit NGO assessment reports to TSU and SACS.
- Debrief with SACS, APAC, TSU officials and respective NGOs.
- Receive SACS approval for continuation of the interventions based on the assessment reports.
- Develop NGO-specific action plans.
- Prepare and submit NGO proposals for funding to SACS.
- Sign contracts between SACs and TSU.

Post-Transition

- Develop post-transition follow-up plans.
- Finalize plans with TSU.
- Plan joint mentoring visits with NACO and SACS.
- Share ATP of PO-TI by TSU.
- Conduct joint mentoring visits to the NGOs. Conduct TA in consultation with TSU.
- Facilitate discussion with SACS to ensure smooth functioning of the projects.
- Phase-out after six months.
- Share NGO directory prepared by APAC to support continued networking and collaboration.

"We proudly state that we were the first MSM CBO supported by APAC to implement a TI project in Chennai and Puducherry. It is not an exaggeration to say that APAC has lifted our team and encouraged us to plan innovative programs among our target group that lifted our image among the community.

Our project with APAC came to an end in June 2011. With technical guidance and motivation, we have signed an agreement with the Puducherry AIDS Control Society. The first installmentwas released by PACS in July 2011, and the project activities were continued without any break and with the same commitment and motivation. We expect continuous mentoring from the APAC team till we get accustomed to our new partner."

—TG.K. Ganesh, Project Director, Sahodaran CBO

LESSONS LEARNED

- Quality interventions supported with capacity building, mentoring, and monitoring systems ensured support throughout transition process.
- Post-transition support by transitioned stakeholders resulted in continuity and sustained performance.
- A state coordination committee on transition was useful in facilitating coordination during transition.
- Adherence to NACO guidelines on staff structure, financial allocations, systems of capacity building and M&E simplified the transition process.

APPENDIX A: SCOPE OF WORK

Global Health Technical Assistance Project
GH Tech

Contract No. GHS-I-00-05-00005-00

SCOPE OF WORK

I. TITLE: APAC EXPERIENCE DOCUMENTATION.

Activity: USAID/India intends to review and document the different systems, strategies, process and activities of the AIDS Prevention and Control (APAC) Project which resulted in improving scale and quality of HIV/AIDS interventions; strengthened systems, evidence-based interventions and institutional capacity; and enhanced coordination and ownership of project activities and HIV/AIDS programs in the state of Tamil Nadu.

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD: SEPTEMBER 1, 2011 TO DECEMBER 15,2011

III. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

The purpose of this assignment is to review and document the strategies, experience and key lessons of the APAC Project in: a) providing technical assistance to different stakeholders; b) scaling-up prevention to care continuum services in concentrated epidemic settings; c) transitioning of project activities to the National AIDS Control Organization (NACO), Tamil Nadu State AIDS Control Society (TANSACS); and d) use of strategic information for program management and policy change. This assignment will also analyze and document the key factors that contributed to the successful coordination between the APAC Project (which is managed by a large NGO) and the national, state governments. Besides, the assignment will also assist the project to identify, document and disseminate best practices and success stories (of both the APAC Project and TANSACS) in HIV/AIDS prevention, care and treatment programs.

The specific objectives of the assignment are to:

- Review, analyze and document the experience and effects of technical assistance provided by the project to strengthen institutional capacities (at national, state, and district level) to implement quality HIV/AIDS programs.
- Review the different models supported by the project to expand access to quality HIV/AIDS prevention, care and support services to Most At Risk Populations (MARP), People Living with HIV/AIDS (PLWHA), Orphans and Vulnerable Children (OVC), and document key lessons that could be drawn from these approaches.
- Review the different approaches adopted by the project and the government of Tamil Nadu, to engage the private sector in HIV/AIDS/other health programs, and document success stories, challenges and key lessons in engaging private sector.
- Analyze the governance and project management systems of the project and document the factors that led to a strong collaboration between the APAC Project and NACO, SACS and other government departments.
- Review and document the project's efforts towards improving evidence, DQA, impact assessment and its effect on program management, policy and advocacy.

- Document the process and key lessons in transitioning project supported activities to NACO, TANSACS and other stakeholders.
- Identify best practices, success stories in HIV/AIDS prevention, care, treatment programs, for documentation and dissemination to national and international agencies.

IV. BACKGROUND

The AIDS Prevention and Control (APAC) Project, a $47.25 million, bilateral project (between the US Government and Government of India) implements HIV/AIDS prevention, care and treatment programs in Tamil Nadu (TN) and Puducherry in partnership with the National AIDS Control Organization (NACO) and local State AIDS Control Societies (SACS). The project started HIV/AIDS interventions in 1995, and is currently in its third and last phase of interventions. The management of the project is by the Voluntary Health Services – a leading NGO providing community-based health care service to rural and poor populations in selected districts of Tamil Nadu.

The APAC Project has played a critical role in engaging civil society in HIV/AIDS programs and established proven systems and strategies for behavior change, service delivery and targeted evaluations, several of which have been adopted by SACS/NACO. The project in coordination with other agencies has played a pivotal role in controlling the HIV epidemic in TN, which declined steadily in adult prevalence since 2001 (from 1.13%) to 0.25% in 2008, and is recognized for its cost-effective approaches, close-collaboration with government, robust systems, technical assistance, innovations, and evidence-based interventions. In its first two phases, the project focused on direct implementation of HIV/AIDS prevention and care services, while in the third phase the emphasis is on providing technical assistance to SACS and other agencies.

The APAC Project has been a flagship project of USAID, and the India mission is keen that the knowledge and successful experience of APAC Project is converted as a strategic asset to benefit other regions and players. In the last 15 years the project has extensively engaged the civil society and private sector for HIV/AIDS programs; undertaken many innovative Behavior Change Communication initiatives; supported several assessments and research studies; and facilitated integrated health programs, all of which can provide critical insights to program planners and policy makers. Besides, the USAID India mission is planning for supporting new designs and the lessons from APAC Project can be very critical and helpful while developing the designs.

V. SCOPE OF WORK

USAID/India intends to review and document the different systems, strategies, process and activities of the APAC Project which resulted in improving scale and quality of interventions; strengthened systems, evidence-based interventions and institutional capacity; and enhanced coordination and ownership of project activities and HIV/AIDS programs in the state. The approaches, experience and lessons will be used to disseminate to other states and countries implementing HIV/AIDS prevention and care programs as well as provide important insights for the new designs being planned by USAID India Mission. The broad tasks to be performed by the consultants include:

- Review of project related literature and documents.
- Review of international and national experience and develop criterion to assess project outcomes and experience vis-a-vis national and international experience.
- Develop interview/data collection tools, guidelines for collecting, analyzing and documentation of information pertaining to the seven objectives.

- Develop panel of key stakeholders for interview.
- Interview key stakeholders at national, state and district level.
- Undertake field visits to obtain beneficiary and civil society inputs.
- Develop criterion and structure for synthesizing the document.
- Identify key strategies, activities and lessons that is critical for dissemination at the national and international level
- Develop criterion and tools to be adopted by the project for documenting best practices and success stories of the project and SACS.
- Present draft observations to USAID, incorporate comments and finalize final report on the APAC Project.

VI. METHODOLOGY

- Desk review – Review of the project documents including project proposal, performance reports, evaluation reports, and related documents. Besides a review of the National AIDS Control Program and PEPFAR guidance is also required.
- Team planning meeting. The assignment work will commence with a two-day Team Planning Meeting (TPM) in Delhi, India. This meeting will allow the team to meet with the USAID India staff to be briefed on the APAC Project and its activities. It will also allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:
  - Clarify team members' roles and responsibilities.
  - Review and develop final assessment questions.
  - Review and finalize the assignment timeline and share with USAID.
  - Develop data collection methods, instruments, tools, guidelines and analysis.
  - Review and clarify any logistical and administrative procedures for the assignment.
  - Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
  - Develop a preliminary draft outline of the team's report.
  - Assign drafting responsibilities for the final report.
- Site visits and interviews – Interviews should be planned with different stakeholders at national and state level including NACO, SACS, TNHSP, NRHM, Principal Secretary - Health, USAID, CDC, Donors/Development partners working in Tamil Nadu and private organizations. Interviews with civil society representatives and beneficiaries at district level needs to be also factored.
  - The Assessment Team will split into two teams and will conduct site visits and interviews concurrently.
  - Team 1 will visit: Hyderabad, Mahabalipuram, Tiruchirappalli and Villupuram.
  - Team 2 can visit: Trivandrum, Kanyakumari, Tirunelveli and Tuticorin.

VII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

1. **Senior Technical (HIV/AIDS) Expert/Team Leader (international):** This Senior Technical (HIV/AIDS) Expert in the field of international HIV/AIDS prevention, care and treatment has an excellent understanding of the global HIV/AIDS strategy and knowledge of the Indian epidemic and programs. S/he should have strong experience in designing, implementing and evaluating programs for MARP as well as in providing Technical Assistance to a range of stakeholders including government, civil society and private sector. S/he should

have also good experience in working on governance, policy, advocacy, community capacity building and innovation. S/he should have proven experience in leading and managing large-scale documentation of various HIV/AIDS programs throughout the world. S/he should be familiar with the functioning of large donor-funded programs in India. A minimum of 15 years of experience in the design and management of HIV/AIDS prevention and control programs is required *(LOE up to 40 days)*.

2. **Private Sector / Alliance building expert (international):** The private sector expert should be of a senior level position having a strong understanding of international initiatives in public-private partnership (PPP)/private sector engagement in HIV/AIDS, health/development programs. S/he should be familiar with the functioning of large donor-funded programs in India. S/he should have a minimum of 15 years experience in designing, managing and evaluating PPP programs in HIV/AIDS, health programs. *(LOE up to 40 days)*
3. **Senior Public Health Specialist (local):** This Senior Public Health Specialist should be a management expert with extensive experience with USAID project design, implementation, and evaluation. The person should have an excellent understanding of USAID operational, management and technical approaches. S/he should have thorough knowledge of project governance of large donor funded programs, including those that are managing a network of NGOs and other institutions, working with government counterparts, as well as of the various management issues related to such projects. In addition, the specialist should have knowledge and experience of HIV/AIDS prevention, care and treatment activities. A minimum of 12 years of experience in the design and management of HIV/AIDS prevention and control programs is required. Having knowledge and understanding of the Tamil Nadu State HIV/AIDS program and government systems would be an added advantage *(LOE up to 36 days)*.
4. **Evaluation Methods Specialist (local):** This expert will have deep knowledge of evaluation methodologies and substantial experience in their practical application. A minimum of 7 years of experience in strategic planning, surveillance, operations research, monitoring and evaluation of global and national HIV/AIDS programs is required. *(LOE up to 36 days)*.

Summary Table: Labor

Labor Category	Maximum LOE
Senior Technical (HIV/AIDS) Expert/Team Leader	40
Private Sector/Alliance Building Expert	40
Senior Public Health Specialist	36
Evaluation Specialist	36

In addition, each team member should have, at a minimum, the following skills and experience:

1. An understanding of the country context.
2. An advanced degree in Public Health, Social Sciences, Business Administration, or other relevant course of study.
3. Demonstrated skill in written and oral communication, including skills in use of relevant computer software packages.
4. Demonstrated knowledge of USAID policies and procedures.
5. Ability to work effectively in, and communicate with, a diverse set of professionals.
6. Ability to work within tight deadlines producing high quality written reports

An illustrative table of Level of Effort (LOE)

Activity	Team Member(s)	Total Team Days	Period of Performance (illustrative)
Mission sends background documents to GH Tech and Team Members			Sept 5, 2011
Review of Documents	All four consultants	5	Sept 12–16
Team travels to country	Senior Technical Expert, Private Sector expert, and Senior Public Health Specialist	2	Sept 20–21
TPM in Country	All four consultants	2	Sept 22–23
Meetings and Interviews with Key Stakeholders	All four consultants	5	Sept 24–29 (One-day may be factored for meetings with officials from the National AIDS Control Organization, Delhi)
Fieldwork	All four consultants	7	Sept 30–Oct 7 (the two teams will conduct fieldwork concurrently in two locations)
Information Analysis and Synthesis (in Chennai)	All four consultants	6	Oct 8–14
Drafting Report (in Chennai)	All four consultants	5	Oct 15–20
Oral Debriefing of Mission staff. Team submits full draft to Mission and GH Tech	All four consultants	1	Oct 21
Stakeholders Presentation (to APAC)	All four consultants	1	Oct 22 (pending availability) or Oct 25
Team Departs Country	Senior Tech Expert, Private Sector Expert, and Senior Public Health Specialist	2 days	Oct 23–24
Mission and GH Tech send technical feedback/comments on draft to Team Leader	Senior Tech Expert		Nov 7
Draft revised by Team	All five consultants	4	Nov 8–11
Mission approves final draft			Nov 18
GH Tech edits and finalizes report		(approx. 4 weeks, no LOE required)	Dec 18

VIII. LOGISTICS

The contractor will be responsible for obtaining visas and country clearances for travel for consultants. In-country logistics to include transportation, accommodations, communications, and office support will be managed by the contractor through a Local Logistics Assistant. A six-day work week is authorized for work in-country.

X. DELIVERABLES AND PRODUCTS

1. **Preparation of Workplan Including Data Collection/Analysis Plan:** During the team planning meeting, the Assessment Team will provide USAID India with a workplan for approval, including a data collection and analysis plan. The general methodology to be used will be reviewed and discussed. Based on inputs provided by USAID India, the team will then be responsible for developing the overall final assessment workplan, defining the responsibilities of individual team members, developing a key informant interview questionnaire, agreeing on a schedule for specific activities, and addressing other operational and logistical issues as needed. The data collection plan and questionnaire created during the TPM will ensure information collected during fieldwork is comparable and consistent.
2. **Oral Debriefing to Mission Staff and Stakeholders Presentation.** The evaluation team will provide an oral briefing of its findings and recommendations to relevant staff in the field as well as to the respective country coordinators, GOI officials and other USAID staff at the conclusion of the visits to the various implementing partners. They will also conduct a separate presentation for stakeholders prior to departure from country.
3. **Draft Report**. The evaluation team will present a draft report of its findings and recommendations to the HIV Point of Contact (POC)/Activity Manager before its return to the United States. USAID will provide comments on the draft report to the team leader within 10 working days of receiving the report.
4. **Final Report.** Ten copies of each report will be provided to the USAID/India HIV POC and two copies will be provided to PPC/CDIE/DI; an electronic version in Word shall also be submitted upon completion.

   The final report should include an executive summary of no more than three pages, a main report with conclusions and recommendations not to exceed 50 pages, including annexes (which should include a copy of this scope of work, tools used to collect information on each of the program components, and lists of persons and organizations contacted).

   GH Tech will provide the edited and formatted final document approximately 30 business days after USAID provides final approval of the report. GH Tech will provide an electronic final copy. The final report will be a public document and will be submitted to the DEC and USAID evaluation registry in USAID/Washington.

IX. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire evaluation team
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications;

The **USAID/India Office** will provide overall technical leadership and direction for the Evaluation Team throughout the assignment and will undertake the following specific roles and responsibilities:

Before In-Country Work

- Respond to all points included in the SOW, including the submission of the final report.
- Consultant Conflict of Interest. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors or NGOs evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.
- Local Consultants. Assist with identification of potential local consultants and provide contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics (i.e., visa letters of invitation etc.).

During In-Country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Support the Evaluation Team in coordinating meetings with stakeholders.
- Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.
- Facilitate Contact with Partners. Introduce the Evaluation Team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-Country Work

- Timely Reviews. Provide timely review of draft/final reports and approval of the deliverables

APAC Project will provide overall leadership and direction for the Evaluation Team throughout the assignment and will undertake the following specific roles and responsibilities:

Before In-Country Work

- Lodgings and Travel. During field visits APAC Project can assist in the logistics. At Delhi we will provide you the contact details of our travel desk (HRG Sita Travels) who can assist in accommodation and local travel.

During In-Country Work

- The APAC Project will take the lead in coordinating meeting with local government officials, civil society representatives and other experts.

X. DOCUMENTS

List and electronic copies of relevant documents will be provided by USAID/India.

APPENDIX B: PERSONS CONTACTED

Contacts are listed with their current position and with a reference to their former position if they worked with the APAC Project at an earlier date.

GOVERNMENT OF INDIA

K. SujataRao, former Secretary of Health, Government of India

AradhanaJohri, Additional Secretary, NACO

SupriyaSahu, Director, Ministry of Information and Broadcasting; former Project Director, TANSACS

GirijaVaidyanathan, Principal Secretary, Health and Family Welfare, Tamil Nadu

Dr. S. Vijahakumar, Commissioner, Rural Development

Panchayat Raj, Special Secretary of Health, Tamil Nadu; former Project Director, TANSACS

K. Deenabandhu, Principal Secretary/Commissioner, Rehabilitation and Welfare, Tamil Nadu;former Project Director, TANSACS

JayashreeMuralidharan, District Collector, Trichy

USAID

Robert Clay, Deputy Assistant Administrator, Bureau for Global Health, USAID

Shanti Conly, Team Leader, HIV Prevention, Technical Leadership and Research Division, Office of HIV/AIDS, USAID

RekhaMasilamani, former PHN Officer, USAID/New Delhi

Kerry Pelzman, Director, PHN, USAID/New Delhi

Dr. Sanjay Kumar, Division Chief, PHN, USAID/New Delhi

Arvind Kumar, Project Management Specialist, PHN, USAID/New Delhi

Sampath Kumar, Project Management Specialist, PHN, USAID/New Delhi

CharuLal, Evaluation Specialist, USAID/New Delhi

CDC

Dr. Dora Warren, Director, CDC/Cambodia

APAC-VHS, CHENNAI

Dr. Ennapadam S. Krishnamoorthy, Honorary Secretary, VHS

Dr. Bimal Charles, Project Director, APAC-VHS,

Dr. T. IlanChezhian, Director Program Operations

S. Santhya, Senior Program Manager, Link Workers Scheme

Dr. P. Mahalingam, Senior Program Manager, Care and Treatment

Ebenezer C. Luke, Program Manager, Care and Support

P.M. Rajaram, Director, Finance and Contracts

S. Lokabiraman, Program Manager, MIS

Gayatri Mishra Oleti, Director, Strategic Planning and Partnership

Dr. A. Edwin Sam, Program Manager, Research

Francis Prosingula, Program Manager, Prevention

Christina T. Dorothy, Program Manager, Strategic Planning and Partnership

R. Shubha, Senior Research Officer

S. Padmaja, Consultant

Bharat Venkat, Intern/Researcher

STATE AIDS CONTROL SOCIETIES

S. Velmani, Joint Director, Finance, TANSACS

Dr. A. S. Valan, Regional Coordinator, TANSACS

Dr. S. Thennarasu, Regional Coordinator, TANSACS

K. Radha, Assistant Director, Nursing, TANSACS

Dr. Rachna William, PPTCT Consultant, TANSACS

B. SathyanRajkumar, Self-Help Group Consultant, TANSACS

Dr. Bubby S. Kumar, Consultant, CST, TANSACS

Dennis, Joint Director, Targeted Interventions, Kerala SACS

TAMIL NADU HEALTH SYSTEMS PROJECT

Pankaj Kumar Bansai, Project Director, TNHSP

Dr. S. Nithianandan, Program Coordinator, TNHSP

R.M. Saravanan, Public Health Research Officer, TNHSP

A. Viswanathan, Public Health Research Officer, TNHSP

Dr. Capt. M Kamatchi, Expert Advisor, TNHSP

Dr. K. Vinay Kumar, TNHSP

Dr. D. Gurusamy, TNHSP

Dr. Jerard M. Selvan, TNHSP

DISTRICT AIDS PREVENTION AND CONTROL UNITS

Dr. Stella Janet, District Program Manager, Kanniyakumari District, DAPCU

Dr. K. A. MerraMohideen, Director of Public Health and Deputy Director of Health, Tirunelveli District, DAPCU

Dr. R. Ranmath, Deputy Director of Medical Services (TB), DAPCU

Dr. B. NarayanaSrinivasan, District Program Manager, DAPCU

S. Shoba, Consultant, DAPCU

JoevalanNiranjan, Program Officer, DAPCU

TECHNICAL SUPPORT UNITS (TSU)

Dr. M. Prasanna Kumar, Team Head and Team Leader, Strategic Planning, TSU/Kerala and staff

Vimal Ravi, Team Leader Targeted Interventions, TSU/Kerala

T.D. Rajeenald, Team Leader, Capacity Building, TSU/Kerala

K. Ananthasivan, Program Officer, TSU/Kerala

S.V. Bardot, Program Officer, TSU/Kerala

Binu George, Program Officer, TSU/Kerala

K.B. Sudheer, Program Officer, TSU/Kerala

K.V. Pramod, Team Leader, Targeted Interventions, TSU/TN and Puducherry

IndhuSivakumar, Team Leader, Capacity Building, TSU/Tamil Nadu and Puducherry

Eswara Murthy, Program Officer, TSU/Tami Nadu

A. Kabilan, Program Officer, TSU/Puducherry

Dr. L. Rani, Program Officer, Targeted Interventions, TSU/Tamil Nadu

PARTNERS: UNIVERSITIES, NGOS, CBOS

Dr. N. Manimekelai, Director and Professor, Department of Women's Studies, Bharathidasan University (Shakthi +)

Dr. L. Ramakrishnan, Country Director, Programs and Research, SAATHI

Dr. A. Satish Kumar, Associate Director, Technical, SAATHI

Berlin Jose, Director, Russ Foundation, Tirunelveli

T.S. Ramkumar, Director, Centre for Social Reconstruction (CSR), Nagercoil, and staff, outreach workers, folk media artists, and peer educators

R. Kingsly, Program Manager, CSR

S. Kannan, Monitoring and Evaluation Officer, CSR

D. Immanuel David, Counsellor, CSR

H. Selina, Accountant, CSR

Mr. Pazhaniapillai, theater expert, writer and trainer

T.G.K. Ganesh, Project Director, Sahodaran CBO

Dr. P. SucilaPandian, Program Director, Community Action for Social Transformation, Tirunelveli

Dr. R. Anburajan, Director, Peace Trust/Peace Health Center, Tirunelveli

O. Martin Luthur King, Project Manager, Peace Trust

J. KrishnaVeni, Counsellor, Peace Trust

S. Antony Raj, M&E, Peace Trust

N. Stephen, Accountant, Peace Trust

Mr. Suresh, Union Secretary, Nuclear Power Plant Project

Four Outreach Workers

S.F. Amalraj, Secretary/Director, Gramodhaya Social Service Society, Trunelveli

Mary Kumaresan, Financial Trustee, CHARDEP, Nagercoil and staff

G. Manikandan, Managing Trustee, CHARDEP

A. Sriram, Program Manager Targeted Interventions, CHARDEP

Selvi J. Sundarakani, Project Manager, staff and outreach workers, PACHE Trust

P. Thirupathiraja, Accountant, PACHE Trust

A. Periaswamy, Counsellor, PACHE Trust

R. Somasundaram, M&E Officer, PACHE Trust

N. Radha, Executive Director, LEAD, Trichy

Lalita, Project Coordinator, LEAD

T.K.S. Senthilkumar, Founder, Ambalayam

T. Ilamurugu, Board Member, Anbalayam

S. Charles, Project Manager, Anbalayam

I. Ambadavanan, Founder and Project Director, PDI

P. Bobby, Project Manager, People's Development Initiative (PDI)

K. Govindaraju, Founder and Director, SEVAI, staff and outreach workers

Prevention Along the Highway state-level peer educators

IFPEC state-level peer educators

A. Anthony, Director, We Care Social Service Society, Kencheepuram

Sundaramurthy, Bro Siga Social Service Guild, Chennai

Dr. Mamorama, Director, CHES, Chennai

Hariharan, Director, ICWO, Chennai

Bakthavatchalam, Director, ARM, Villupuram

MaaGurudasi, Isha Foundation, Coimbatore

Muthuselvan, DRP, CSST, Turuvannamalai

PRIVATE SECTOR

S.K. Murthy, Chief Executive, Media Vision

A.V. Surya, Vice President, IMRB

Dr. Ravi Raj William, Honorary Director, CCOORR

M. Subburajan, Finance Manager, CED

A.S. Sankara Narayan, Managing Trustee, NMCT

K. Arulvel, Executive Director, Sreshta Communications

V. Thennarasu, Program Manager, Hope Foundation

Apollo Clinic

Standard Chartered Bank

CONSULTANTS

Dr. Mohamed Yussaf

Benjamin Franklin

SatchidhanandhaValan

Jacob C. Varghese, Executive Director, I-TECH

Chitra George

Dr. Jeyasingh

Dr. Sivaprakasam

Dr. Joseph Williams

Dr. Jeyaseelan

Dr. Manoharan, I-TECH

Dr. Usman

Dr. Prabhu Das

Dr. B.R. Desikachari

APPENDIX C: REFERENCES

APAC Annual Report 2008-09.

APAC Annual Report 2009-10.

APAC Annual Report 2010-11.

APAC Project Eighteenth Amendatory Agreement, 2007.

APAC Tripartite Agreement among NACO, USAID & VHS, 2007.

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Midterm Evaluation: The Synergy Project, APAC, May 2000.

MSM District-Level Communication Campaign Evaluation (DLCC), 2010.

Peer Education: Successful Pathway to Promotion of Healthy Sex Behavior, APAC, ND.

Project Nakshatra - A PPP initiative for STI /HIV management of MARP & PLWHA, 2010.

Rapid Assessment on CBO Management Training for District Level Networks (DLNs), 2009.

Reaching the Un-reached: An Exploratory Study of the Hidden and Difficult to Reach Sex Workers in Tamil Nadu.

Reflections Internal Evaluations of Strategies and Processes of APAC, 2002

Report on the Global HIV/AIDS Epidemic, UNAIDS, 2000.

Risk Assessment on Cine Dancers/Junior Artists in Chennai Film Industry.

Shakthi +: Comprehensive Care and Livelihood Support: Assessment Report.

State Level Communication Campaign [SLCC] Evaluation, 2010.

Willingness to Pay (WTP) for Medical Services at the Private Health Facilities by People Living with HIV/AIDS (PLWHA).

APPENDIX D: METHODOLOGY AND TOOLS

The APAC Documentation team consisted of four members, comprising an HIV/AIDS specialist/team leader, a program management specialist, a private sector specialist and an evaluation specialist. Team members carried out a desk review of APAC documents, including annual reports, legal agreements, research and evaluation studies and publications and were provided with extensive additional background material by APAC. After an initial briefing from USAID PHN in New Delhi, the team travelled to Chennai for a week's presentations and discussion on the program with the program and technical officers of the APAC team.

Following this, the team split into two sections for one week's fieldwork. Two team members focused primarily on field visits to NGOs working with the private sector and two travelled to interview NGOs involved in targeted interventions—although these activities overlapped. The structure of the meetings with NGOs and government offices was focused on presentations from the organization's officers, followed by a question and answer session and the opportunity to interact with the target population of MARP or health providers.

Additional discussions were held with key figures during the 17 years of the APAC Project, including present and prior representatives of the Indian government at NACO, the Tamil Nadu Health Ministry, TANSACS, and the Tamil Nadu Health Systems Project and present and prior officers from USAID/India who had worked on APAC. The team also had extensive discussions with and input from APAC staff and stakeholders, including staff of private hospitals, NGOs, CBOs, and officers from private companies and media agencies. Additionally, three workshops were conducted to bring together NGOs, private sector representatives, and consultants to provide feedback on their experiences with APAC. Examples of the questions used by the team are attached. A final debriefing, with a presentation from the team, was held with USAID on September 22, 2011.

The team requested APAC to complete several matrices that set out the major components of the program. Information on capacity building of NGOs was requested on the type of training, strategy, impact, synergies, and value added of programs delivered by each NGO. A matrix on technical assistance to government requested similar information. Information was provided on the numbers reached and NGOs involved in the different phases of TIs with MARP, bridge, and vulnerable populations. Data on research and evaluations studies was also requested, including the date, type, objectives, and key findings of the studies and their impact on the program.

The in-country assessment was carried out from September 22, 2011, through October 26, 2011. The report focuses on key issues in the six main areas of interest in documenting APAC: its governance and management systems and approaches; models used in addressing the prevention to care continuum; technical assistance; APAC's interactions with the private sector; the research, monitoring, and evaluation continuum, and the transition of programs from APAC as the program ends. The audience envisioned is primarily program managers at NACO, USAID, and other implementing agencies.

QUESTIONS FOR GOI AND USG OFFICIALS ON THE APAC PROJECT:

1. Please share your thoughts on the significant contributions/achievements of the APAC Project in controlling the HIV/AIDS epidemic in Tamil Nadu.
2. What were some of the contributing factors that led to the achievements of the project?
3. What lessons can USAID draw and apply globally from the APAC Project's experience?

4. Are there any special moments from your association with the project that you would like to share?
5. The project plans to have a final evaluation in mid-October. Are there any specific evaluation questions/areas that you would suggest be covered in the final evaluation?
6. Please share any additional comments that you have on the project.

APAC was also asked to provide information on the achievements of the project.

QUESTIONS FOR CONTACTS INVOLVED WITH THE PROJECT, FOR EXAMPLE STAKEHOLDERS, NGOS, PRIVATE SECTOR COMPANY REPRESENTATIVES:

As above, but included specific questions for each interviewee or organization related to the stage of the project during the time period of their service or their particular area of interest (e.g., on APAC's experience working in health systems strengthening). For stakeholders, specific questions related to the area of work of specific NGOs, CBOs, private sector partners, consultants, and APAC staff, on e.g., peer education and community mobilization processes and successes; referral systems for STI or counseling; monitoring and evaluation systems; and the processes of engagement and outcomes of working with the private sector.

The questions for these organizations and individuals were:

1. What was the value added by APAC to your existing activities?
2. What have been your major activities and innovations under the APAC Project?
3. Which were the most significant lessons learned in your program under APAC?
4. Which APAC approaches/program contributed best to your other projects?
5. How did you sustain the project (after APAC ended support in Phase II)?
6. How have APAC's interventions in capacity building and exchange contributed to your results?
7. What are some of the highlights of APAC's work? Were there any persons or activities that made a major impression?
8. Were there any difficulties or barriers to the success of the project? If so, what were they and how could they be overcome?

Target populations were also asked about personal stories of increased responsibility and involvement in the project. Specific questions to particular organizations or groups were:

PRIVATE SECTOR ORGANIZATIONS:

1. How did the partnership start? What motivated your company to get involved in this partnership? What investment did the company make during the initial period of the partnership?
2. Did the partnership include a formal MOU? If so, were the roles and responsibilities of the core partners clearly spelled out?
3. Did the partnership set up a Project Management Committee or a Partnership Committee to manage its activities?
4. Which partner was responsible for the collection of data?
5. What did your organization bring to the partnership in terms of resources?
6. What were the partnership's main goals for your organization?

7. What key lessons can you share from having been involved in this partnership and what key benefits did you derive from it?
8. What would have made this partnership sustainable?
9. Does your organization have any suggestions or recommendation for APAC in building such partnerships in the future?

STRATEGIC INFORMATION

1. How is the use of SI an integral part of program planning and monitoring?
2. What are the different sources and tools used to collect information at different levels (e.g., peer educators, health care providers, etc.)?
3. How are these triangulated?
4. How is data used by the program team, e.g. for program planning?
5. How is SI disseminated to other stakeholders?
6. What are the different areas in which research is conducted?
7. How is research used for planning purposes?
8. How are research findings disseminated to different stakeholders?
9. How is data quality maintained at all levels? What is the frequency of data quality audits?
10. What are the challenges faced in data collection and analysis?
11. What is the support provided by APAC and the TSU to strengthen the capacity of the NGO program team in collecting and analyzing the data?

TRANSITION ISSUES

The focus of questions was on the operationalization of transitioning and post-transition support.

1. How was the planning part of APAC's Phase III?
2. How was it included in the SAC's annual plan?
3. How were different stakeholders (state government, NGOs, the community) involved in the process and how were negotiations handled?
4. How were systems aligned with the national and state systems?
5. What was the preparation for transition? How was orientation and capacity building done to ensure NGOs were fully ready to work within the government system, and aligned with national guidelines?
6. Was there an impact on the operations of the NGOs: staff turnover, reporting issues, funding issues? Service utilization among the community pre- and post-transition?
7. What were the challenges faced by the NGOs during and post-transitioning?
8. What support was provided by the SACS and TSU? By APAC?
9. Can any impact on the program be seen after transitioning?

ROUND TABLES:

APAC also held three round table meetings for the team with NGOs, support agencies, and consultants to address the following issues:

NGOS:

1. What type of support have you received from APAC and how has it benefitted your organization and in scaling up the program?
2. What type of system was introduced by APAC and how was it useful?
3. Please share some of the innovations introduced in IT.
4. What do you think APAC could have done better?
5. What are your best memories of APAC?

SUPPORT AGENCIES:

1. Can you share with us the ways you got involved in supporting APAC?
2. What are the few significant initiatives implemented or adopted already or which have the potential to be adopted by the state in the future?
3. What are the efforts by APAC that facilitated strengthening the capacity of the agency to work in the HIV/AIDS field?
4. What do you think APAC could have done better?

CONSULTANTS:

1. Can you share with us the ways you got involved in supporting APAC?
2. Has APAC facilitated building capacity in your professional work and how?
3. Has the work with APAC provided an opportunity to widen your professional work in India and contribute beyond Tamil Nadu? How?
4. What do you think APAC could have done better?
5. What are your best memories of APAC?

DATA COLLECTION TOOLS FOR OBJECTIVES 1, 2, 5, AND 6

Objective 1: TA Support to Government, Civil Society and Private Sector

A. Capacity Building of NGOs

S. No	NGO	Type (TA, Training, etc.)	Strategy	Impact	Synergies	Value Added—such as Empowerment, Individual or Group

Please add:

Quotes:

Graphs

Data source

Cross-cutting issues such as gender, use of information technology, community mobilization

2. TA to Government

S. No	Government	Type	Strategy	Impact	Synergies	Value Added—such as Empowerment, Individual or Group

Please add:

Quotes:

Graphs

Data source

Cross-cutting issues such as IT, gender, community mobilization, etc.

Objective 2: Prevention and Care Models

Type of Intervention	Location	Strategy	Impact and Accomplishments	Challenges	Capacity Building (tech, management, finance/admin, SI, DQA)	Important Sources of Reports or Data
Reaching MARP: FSWs MSM Migrant workers Other						
Reaching PLWHA Individuals PLWHA Network (Shakti+)						
Home-based care						
Private provider Network						
OVC Trust						

Please add:

Quotes:

Graphs

Data source

Cross-cutting issues such as gender, use of information technology, community mobilization

APPENDIX E: CASE STUDIES

CASE STUDY 1: IMPROVING ICTC IN THE PRIVATE SECTOR

Purpose

TANSACS provided ICTC at 800 government facilities and supported 42 private hospitals. To assist TANSACS in expanding services, APAC conducted a district-wide mapping of private hospitals. The mapping showed that only 465 out of 2,500 private hospitals met NACO's criteria for initiating ICTC—of which just 113 private hospitals were willing to initiate ICTC/PPCT services.

The objectives were to increase access to ICTC, PPTCT, and STI/TB/ HIV treatment in the private sector for HRG and pregnant women. APAC implemented the program in partnership with SAATH II, the Indian Medical Association, the Nursing Board, and PSG Medical College.

Activities

APAC conducted assessments in the 113 private hospitals willing to initiate services, which led to a memorandum of understanding to establish ICTC in 100 facilities. This was followed by orientation of the medical team; site preparation and supply chain management; development of training curriculum; counseling and lab diagnosis training; and on-site mentoring. TANSACS supplied commodities. Strong linkages were established with the DAPCU for supply chain and monitoring visits.

Outcomes

By October 2010, APAC helped initiate ICTC and follow-up services at 87 private hospitals across 26 districts. A training curriculum educated 494 health care providers and created awareness among 1,424 staff. From June 2010 to December 2010, 18,263 clients accessed ICTC, of which 290 tested HIV-positive. The program was transferred to TANSACS in January 2011.

CASE STUDY 2: A NETWORK MODEL FOR PLWHA TREATMENT: IRT PERUNDERAI HOSPITAL

Purpose

This model demonstrates issues that arise when working with the private sector, including determining suitable institutions, managing expectations, and identifying a unifying role (in this case, as a training center) that benefits the surrounding community. The Technical Assistance Component Grant of 2005 mandated that APAC identify four private institutions that could be improved to provide clinical treatment to the general public. At the time, public services for PLWHA treatment and care were limited and sound knowledge on how to treat HIV was in short supply (APAC Health Care Providers' Survey, 2004). Identifying a hospital was difficult. Most of the few private hospitals that treated AIDS patients were unwilling to take part because of the stigma. IRT/Perundurai (a 600-bed Medical College Hospital in Erode district and supported by the Institute for Road Transport) had a palliative care program and was finally identified as a partner. The hospital was well-known among the PLWHA community and committed to providing care.

Objectives and Activities

The objectives of the project went beyond strengthening one hospital. They were to develop IRT as a training and demonstration center in order to expand the quality of care and treatment

for PLWHA across adjoining districts and private sector hospitals in Erode. This was accomplished through a multi-faceted program to build the capacity of IRT Perunderai and surrounding private providers. Funding for this three-year program was through a public-private partnership between APAC, which contributed 70 lakhs ($140,000); IRT Perunderai, which contributed 80 lakhs ($160,000), including manpower, space, and a subsidy for treatment; and SACS, which contributed 90 lakhs ($180,000) for test kits, medicines, and ART.

Institutional gaps and challenges were addressed through the following activities:

- Improving high-quality diagnostic services in the hospital by establishing a training hall.
- Building a linked network of 10 private hospitals to support follow-up for patients discharged from IRT. Hospital doctors and nurses were trained by I-TECH; a three-day curriculum was developed for future training.
- Strengthening inter-departmental coordination for better cross referrals. A central data unit and common registry were set up; a database was established for individual PLWHA; and protocols and manuals were developed on quality of care.
- APAC partnered with the National Institute for Epidemiology to train doctors on research.
- Creating demand for services through networking with HCPs and PLWHA networks. Monthly coordination meetings were held at the hospital for all partners.
- Mobilizing resources to publicize services (for sustainability) was planned, but proved unsuccessful.

Outcomes

While this model was difficult to initiate due to private sector reluctance, it had positive long-term effects. The project transformed IRT PMCH into a regional center for HIV/AIDS training and treatment in the private sector, with an ongoing research capability. IRT's private hospital network and institutionalized feedback from PLWHA networks still continue. The project's performance led to IRT being selected by TANSACS as the only private Link ART facility in Tamil Nadu.

CASE STUDY 3: IMPROVING PHYSICAL, SOCIAL, AND ECONOMIC RESILIENCE: A PILOT PROGRAM FOR HIV-POSITIVE SEX WORKERS

Purpose

Shakthi+, a pilot program for the Comprehensive Care and Livelihood Support (CCLS) was launched in February 2010 and designed in consultation with four NGOs—SEVAI, LEAD, Anbalayam, and PDI—in Trichy. The Women's Studies (CWS) of Bharathidasan University, Trichy, and the district administration were involved to ensure sustainability. Focused on HIV-positive FSWs, the primary objectives were as follows:

- Enhance cognitive and life skills in order to reduce vulnerability
- Introduce skills and options for alternative and sustainable livelihoods
- Improve the quality of life by building skills

Methodology

The study design employed a randomized control trial (RCT) to study the effect of the CCLS intervention. At baseline, 48 HIV-positive FSWs were assessed. Using a response-adaptive (willing/unwilling to participate) method, 32 FSWs were randomly allocated to the experimental group (EG) and 16 to the control group (CG), with a ratio of 2:1. The EG received intensive cognitive behavior intervention, capacity building, alternative income generation training and

placement—as well as the pre-existing care and treatment. The CG continued to use pre-existing services. Both groups were assessed after 90 days using the same protocols used for the baseline.

Process of Shakthi + (CCLS)

After an extensive literature review, the team devised four phases for the CCLS Project, which were based on psycho-social, economic, cultural, and spiritual factors of FSWs in Tamil Nadu. The four phases of the CCLS Project include the following:

- **Assessment Phase.** As described in the methodology section, an EG of 32 FSWs and a CG of 16 FSWs were assessed on 11 standardized instruments before the interventions and again after 90 days
- **Skill Enhancement Phase.** The intensive 90-day training phase including field tours, site visits, and classroom training covering psycho-social components, soft skills, and business management.
- **Entrepreneur Development Training Phase.** Participants were placed in jobs based on their capacity and encouraged to take part in individual/group enterprises with appropriate support, mentoring, and placement. APAC and local NGOs played an integral role in the process to leverage government and private resources to support the availability of jobs.
- **Placement and Transition Phase.** Participants were transitioned to "on-the-job" activities with participatory planning and support, including financial support and mentoring. Participants were encouraged to selectalternative livelihoods, rather than sex work.

Outcomes

The final evaluation shows that the health-seeking behavior and health status of the participants were significantly improved. Solicitation for sex work as reported and monitored by NGO staff decreased, while quality of life and cognitive behavior has improved. After one year, 56% of participants were engaged in alternative job opportunities; and 37.5% started their own small business with financial support from the district administration. Overall, 80% of participants abandoned sex work (20% remain in the sex industry). Although this is not a large-scale model, it highlights multiple factors that contribute to a successful transition from sex work to sustainable, safe livelihoods. Overall, the CCLS program implemented a holistic approach that resulted in positive outcomes. As FSWs improved their skills and sought alternative livelihoods, they were more apt to reduce negative health behaviors and maintain positive health behaviors, which, in turn, improved their ability to maintain employment and relationships.

CASE STUDY 4: EMPOWERING NGOS THROUGH CAPACITY BUILDING

Target Group

NGO staff, including program coordinators, counselors, PLWHA, and outreach workers.

Need

NGO staff required increased technical knowledge, combined with managerial and planning skills. This capacity building improved the scope and effectiveness of outreach programs as well as accountability; it also motivated staff and created a culture of self-improvement and entrepreneurialism. Overall, capacity building for NGO staff adds value to the broader healthcare system.

Process

Capacity building included trainings, ranging in length from a few hours to five days. Trainings involved lectures, focus group discussions, field visits, PowerPoint presentations, handouts, role playing, demonstrations, problem-based learning exercises, case analyses, simulations, and learning games. Module-based training manuals were also developed. Central to the process was identifying specialized institutions to participate in the trainings. These included the South India AIDS Action Project (SIAAP) and Christian Medical College (CMC) in Vellore, which could conduct trainings on specific topics, such as counseling, research, and biostatistics.

Through TOT sessions, specific NGOs were then able to also provide training to other NGOs, PLWHA networks, medical care providers, and condom retailers. Select NGOs were also established as demonstration centers, from which other NGOs could learn about effective models and best practices for outreach work and NGO management. The broad range of topics covered in these trainings included CSM; sex and sexuality; proper condom use; selling skills; communication skills; Indian HIV/AIDS statistics; BCC; peer education; enabling environment; care and support; home-based care; referral linkages; needs assessment; situational analysis; syndromic case management and counseling; advocacy; sustainability; information system management; organizational management; and problem resolution.

For PLWHA networks, capacity-building initiatives focused on legal rights; communication skills, such as effective public speaking; networking; administrative, financial and technical management; evidence-based project planning; setting indicators; and group work.

Outcomes

NGO staffs are motivated and able to more effectively deliver STI and HIV/AIDS programs during TIs. Staffs improved their managerial, research, planning, and accounting capacities. They also increased their technical knowledge on HIV/AIDS epidemiology, accounting procedures, computer use, proper condom use, motivational and communication techniques, and CSM. Thus, they employ evidence-based planning strategies so as to innovate and reach a larger proportion of the HRGs. Many NGO staff now conduct their own trainings or operate as demonstration centers, thereby building capacity for other NGOs, condom retailers, health care providers, and PLWHA. NGO trainings also serve to further decentralize and strengthen the broader health system. NGO leaders are better equipped to run their organizations and motivate employees, while staff understand the tenets of teamwork and collaborate effectively to problem solve.

CASE STUDY 5: CAPACITY BUILDING FOR HEALTH CARE PROVIDERS

Target Group

Health care providers—including allopathic and registered medical practitioners, nurses, auxiliary nurse midwives (ANM), midwives, pharmacists, and counselors—all of whom work in HIV/TB/STI, reproductive health and other areas, primarily in private and non-governmental sectors

Need

Many MARP avail medical services for STI care and treatment from private practitioners. However, there is much stigma attached to STIs and treatment. When clients seek treatment for STIs, they must receive prompt, respectful, and effective treatment on the same day. Rapid treatment further serves to reduce the possibility of transmission of STIs/HIV. Health care providers need to be sensitized to the specific social and medical needs of these clients who require CT and/or treatment. Health care providers also need the technical knowledge to utilize

the STI syndromic case management strategy advocated by the World Health Organization (WHO). Syndromic case management provides a routinized system by which HCPs can treat patients who might by asymptomatic or show signs of multiple STIs. This method decreases costs and time associated with diagnosis and treatment. Regular testing and treatment adherence can be improved through capacity building of HCPs; they could then better serve the needs of MARP and PLWHA; ensure higher client satisfaction; and encourage positive living and safer sex practices.

Process

The training process ranges from 2 to 16 days, depending on the group and the stated objectives, and includes lectures and discussions as well as condom demonstrations. Frequent refresher trainings and update sessions reinforce key lessons; address any difficulties faced by HCPs; and provide new information. Health care providers are also provided with various charts and display items, which depict in a clear fashion the methods of syndromic case management, to post in their clinics. Specialized institutions were selected to facilitate specific training areas—these included Meenakshi Mission Hospital and Research Center (MMHRC); Christian Council for Rural Development and Research (CCOORR); the RMMC CETC (Continuing Education and Training Centre) at Annamalai University; the PSG Institute of Medical Sciences and Research; and TNVHA (an association of voluntary organizations working for health promotion in Tamil Nadu and Pondicherry). These institutions had a long-standing relationship with APAC and are highly skilled in training HCPs on HIV and sexual health.

The various capacity-building initiatives covered such topics as the epidemiology and pathogenesis of STIs/HIV/AIDS; stigma reduction; the rationalization of ART; diagnostic processes; signs of opportunistic infections; nutrition; potential problems in managing STIs; STI syndromic management; condom promotion; BBC; voluntary CT; patient education; referral linkages; clinical features of HIV disease; community care; management of occupational exposure; post-exposure prophylaxis; prevention of mother-to-child transmission of HIV; universal barrier precautions for general practice; social, legal, and ethical issues in dealing with patients; documentation processes; and follow-up. Counselors were trained about stigma reduction; proper condom use; treatment adherence; and partner testing. Nurses, ANMs, and midwives were trained on stigma reduction; brokering doctor-patient relationships; how to help a doctor make a diagnosis; and how to empathize with patients.

Outcome

Health care providers have increased knowledge about HIV and STIs. They are able to treat STIs using the syndromic management approach in an effective, cost-efficient, and rapid fashion. The HCPs can recognize the clinical signs of HIV and opportunistic infections, allowing for earlier diagnosis, treatment, and management. They are aware of the relevant referral linkages, and know how to make proper referrals. They understand the principles of rational drug use to ensure the highest quality of care for patients. The HCPs know to use universal barrier precautions, and are equipped to manage exposure cases. They also have a better understanding of the issues facing particular patients and are able to provide better quality service. They are equipped to talk to patients about behavior change and offer support on social issues. They understand why it is important to treat patients from HRGs, and how to treat them with respect. They also understand how to reduce stigma associated with STIs and STI treatment. Module-based manuals and IEC materials have been produced and can be of use in other areas.

CASE STUDY 6: CAPACITY BUILDING FOR CONDOM RETAILERS

Target Group

Condom retailers, especially small condom retailers in rural areas (for example, in paan shops, tea stalls, etc.).

Need

Condoms, when used properly, are the simplest and best means of preventing HIV infection. It is particularly important that FSWs and MSM, who are part of the HRG for HIV infection, have a consistent and convenient source from which to procure condoms. Most condom manufacturers focus on condom retailers and pharmacies in urban areas, and neglect rural areas and small retailers.

Furthermore, there is a lot of stigma associated with both selling and purchasing condoms. This stigma prevents retailers from stocking and displaying condoms and members of HRGs from purchasing them. Even where condoms are available, stigma contributes to the poor treatment of clients purchasing condoms.

Condom retailers needed training to understand the importance of selling condoms, how to treat customers and how to increase sales. Building capacity of condom retailers ensured that condoms reach more of those who are sexually active, thereby reducing the incidence of new HIV infections.

Process

NIS Sparta is a leading organization that works with corporations on improving customer relationships and overall performance. APAC recruited NIS Sparta to train NGOs on how to identify retailers; how to conduct a needs assessment; how to provide training; and how to provide post-training follow-ups. It also developed curriculum and training modules. NIS Sparta and trained NGOs provided training to condom retailers.

The half-day training included lectures and discussions. Prior to training, NGOs (which worked with HRGs) identified potential retailers located in or near hot spots and sex soliciting areas, so that access to condoms would be available where most needed. Training focused on reducing stigma of both the product and the client. Retailers also learned how to display condoms; how to increase sales; and how to treat clients with respect. Condom retailers were trained on the basics of HIV/AIDS. They were informed about their contribution to preventing HIV/AIDS by selling condoms. This was a particularly effective approach to engaging and motivating condom retailers.

Outcome

Condom retailers understand the basics of HIV/AIDS, as well as how condoms prevent the spread of HIV infection. They understand and feel motivated by their role in HIV/AIDS prevention. They feel more comfortable selling condoms and treat customers with respect, decreasing the stigma associated with condom sales and purchase. They increase sales of condoms through effective marketing and display techniques.

NGOs understand how to select and train condom retailers, as well as how to provide support and follow-up to these retailers. They are able to lead training sessions independently. This ensures that HRGs have consistent access to condoms in or near hot spots or sex soliciting areas. Condom manufacturers have also shown greater interest in supplying condoms in rural areas through small retailers,given that condom demand has increased through these programs.

CASE STUDY 7: PARAMESWARI'S STORY: "THEY REALLY TAKE CARE OF US"

She may work in the sex industry, but Parameswari has been empowered through her role as a community health educator (CHE) through the APAC program. When asked about the Nakshatra program, which is focused on providing accessible, stigma-free, and quality care to MARP, she says of the doctors: "They really take care of us." She and others describe the doctors as taking time to listen, to provide care, and to counsel them.

While Parameswari and other FSWs used to go to the government hospital, the long lines and disapproving looks from other patients made her uncomfortable. Now with Nakshatra, she feels welcome—and as a CHE, she encourages other FSWs to use services that are more accessible. "Nakshatra is well located because it's in a hospital/consulting room, and women don't hesitate to go there," she says. "We take them [FSWs] ourselves. Otherwise there is a tendency to take it easy and postpone a doctor's visit." She and two other CHEs have taken 70 women for checkups every three months. "Seventy was the target and we have already reached it," Parameshwari says. She also says she does not mind paying the 30 INR, as the more typical cost is a minimum of 200 INR. And the quality can't be beat. "It's the very best," she says.

CASE STUDY 8: A PARTNERSHIP FOR PROTECTION: OFFERING ICTS TO TRUCKERS AND FSWS

About the Partners

APAC-VHS joined with the Apollo Dealers and Consumer Welfare Trust (ADCWT) and the Victoria Educational and Social Welfare Trust (VEST) to create a PPP to offer ICTS for STI/HIV to truckers and FSWs. The ADCWT is a creation of the private corporation Apollo Tyres Ltd. A key corporate investment is awareness and prevention of HIV/AIDS among its direct stakeholders—primarily the trucking community, its employees, and the communities within which it operates. The VEST is a non-profit public charitable trust that works with marginalized and underprivileged communities—especially poor children with physical disabilities, senior citizens, orphans, and poor women. The trust supports formal and informal education; health care clinics and community health, and community development.

Goals

The PPP between ADCWT, APAC-VHS, and VEST was established with the objective of providing integrated counseling and testing services for STIs and HIV for truckers, and FSWs as a secondary target population in locations where truckers stop. The partnership started on April 27, 2006.

Governance Structure

Governance and accountability were the hallmarks of the partnership. Apollo Tyres and APAC developed the necessary procedures to ensure good governance and accountability. ADCWT and APAC-VHS guided the strategic and programmatic approach, while VEST implemented the program. Weekly review meetings examined progress and monthly meetings assessed the planned activities for the month, as well as achievements and performance. The partners appointed VEST as the Chief Executive, a role that manages the functioning of the health care clinic. A medical officer runs the clinic; overseeing routine activities and offering guidance and support to the staff. Monthly technical and financial reports detailing the clinic and outreach activities and financial details are prepared and sent to partners for review and consolidation.

The partnership processes and activities are guided by a formal memorandum of understanding, which details the scope of work and terms and conditions of the partnership. Roles and responsibilities of all three partners are clearly defined. ADCWT provides funding for the Apollo Tyres Health Care Center, including infrastructure, medicines, clinic staff, and publicity materials. VEST enables on-the-ground operations, such as setting up and maintaining the clinic; mobilizing the truckers and FSWs; establishing linkages with other stakeholders, such as transport companies, drivers associations, government hospitals, and other NGOs; organizing outreach activities; and maintaining relevant records and registers as per NACO guidelines. The testing setup is funded by VHS under APAC, as well as training and capacity building of the VEST staff. This PPP has been successful in its outreach program in Coimbatore.

Review and Reporting Mechanisms

There are defined internal and external monitoring and review systems for project outcomes built into the partnership. VEST prepares monthly technical and financial reports, which are submitted to Apollo Tyres for review and control. Consolidated reports on activities are prepared annually and for the period from inception. Based on the financial report, financial support is given on a quarterly basis by Apollo Tyres. Apollo Tyres also conducts an annual audit and examines copies of all vouchers, bills, and bank statements. VEST conducts the statutory auditing annually. Apollo also conducts regular monitoring visits to the project site.

This PPP was developed following APAC's three-phase approach of: (1) partnership exploration; (2) partnership building; and (3) partnership maintenance. The project is in the maintenance phase (nearly two years following the initiation of this PPP). Clients value the access to all health services—including general health checkups, medicines, and STI/HIV CT—in one place.

Program Outcomes

A large target community has been reached:

- 2,874 truckers enrolled with a monthly subscription and have received general treatment.
- 483 (17%) tested positive for STIs and received treatment.
- 211 commercial sex workers enrolled and received general and STI treatment.
- 1,103 truckers—as well as 150 men and 195 women from the general population—have undergone voluntary CT, with 23 people testing HIV-positive.

Partnership Outcomes

This PPP model has served as a replicable model for many APAC-supported NGOs in Tamil Nadu, who approached other corporations in their respective locations for similar partnerships. For VEST, this PPP helped leverage additional resource support from additional corporations in Coimbatore, including the Coimbatore City Lorry Owners Association, Coimbatore City Lorry Booking Agents Association, and the Coimbatore Light Commercial Vehicle Association. In addition, oil companies such as BPCL, IOC, and HPCL have joined the partnership, and are using the services for their tanker lorry owners and cleaners. Gas stations, such as Indane and Bharatgas, also support the project and use its services.

Scale-up

With an increasing user base, VEST realized the need for an outreach program to cater to the needs of truckers in an extended intervention area—over a stretch of 60 kilometers. After negotiations with Apollo, the program is being implemented. Additionally, the PPP established a voluntary CT center on the same premises of the Apollo Health Care Center.

Lessons Learned

This PPP clearly demonstrates that strategic partnerships can be effective and innovative in addressing the needs of HRGs. Further, it can act as a model for replication, highlighting success factors such as a well-defined governance structure and internal and external monitoring and review systems, as well as opportunities that come with PPPs, such as leveraging of resources.

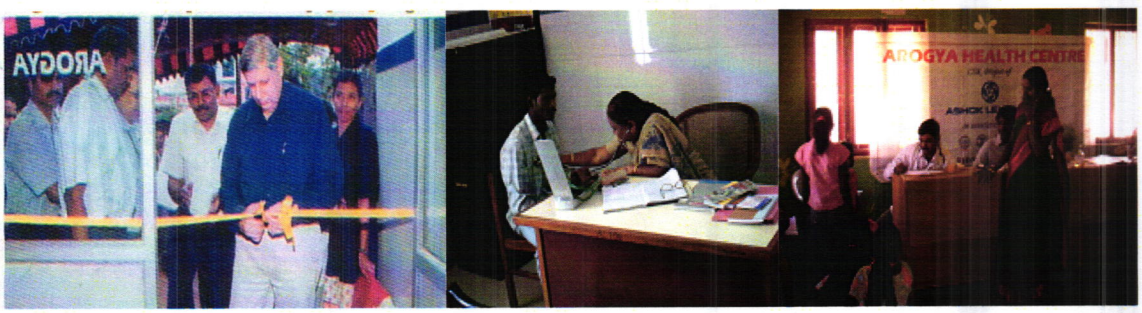
APPENDIX F. SUMMARY OF KEY STUDIES UNDER APAC

S No	Name of the Study/Research/ Evaluation	Year	Objectives	Key Findings	Impact on the Program/Lessons Learned
1	The Quality and Availability of Condoms in Tamil Nadu (TN)	1996	To establish baseline data on condom availability and quality. To assess accessibility and availability of condoms TN. To assess perception of manufacturers, retailers and end-users.	This study revealed the status, in terms of availability, accessibility, and quality, of condom distributors and retailers in the state.	The findings supported the design of condom promotion strategies; social marketing plans; and how to reach out to retailers and manufacturers.
2	Community Prevalence of Sexually Transmitted Diseases in Tamil Nadu	1999	To understand the prevalence of STI symptoms, the etiological conditions in TN, and the risk factors associated with this.	The overall prevalence of STI, including Hepatitis B and HIV, was 15.8% and the prevalence of classical STIs was 9.6%	The study indicated the high prevalence of STIs among the community, which helped to develop improved programs for prevention.
3	Community Prevalence Study Among General Population	2003	To determine the prevalence of selected STIs among the general population—including syphilis, gonorrhea, chlamydia, cancroid, herpes simplex virus 2, hepatitis B and HIV. To assess prevalence of the following syndromes of STIs: genital ulcers, urethral discharge, enlarged lymph nodes in the groin area, and scrotal swelling.	The prevalence of STI was 10.6% HIV prevalence was 0.7% to 1.4% among males and 0.3% among females. The prevalence of STI was similar in urban and rural areas.	This study allowed for comparison of STI prevalence with the earlier study and informed the design of appropriate programs for the general population.
4	Reaching the Un-Reached: An Exploratory Study Of Hidden and Difficult to Reach Sex Workers in Tamil Nadu	2009	To understand the behavioral dynamics of hidden and difficult to reach sex workers. To understand the challenges in identifying and reaching out to them. To identify possible strategies/ approaches that are preferred by women/men involved in the sex industry that would help them access STI/HIV/AIDS information and services.	Most subjects were aged 18 to 35 years. Side actresses (22.3%); escorts (80%); students (43%); and business people (75%) reported that they did not use condoms during every sexual act.	The study indicated that programs targeting these hidden sex workers are vital to reduce risky behavior and to increase access to various HIV/AIDS related services. Findings helped to develop prevention strategies and communication tools to reach out to these groups.

S No	Name of the Study/Research/ Evaluation	Year	Objectives	Key Findings	Impact on the Program/Lessons Learned
5	Willingness to Pay by People Living with HIV/AIDS (PLWHA) for Private Medical Services	2009	To understand the treatment-seeking behavior of PLWHA when ill and the type of services they access. To assess their willingness to pay for medical services at private facilities that subsidized cost according to income levels.	47% of PLWHA seek treatment at private health facilities and 43.8% from government health settings. 93.6% of PLWHA expressed willingness to pay for medical services at a subsidized cost at private facilities.	This study shed light on the need for health care services; and the willingness of PLWHA to pay for private services, which was vital to start PPP initiatives specific to the PLWHA community.
6	Facility Assessment of Secondary Level Public Hospitals in Tamil Nadu (272 Government Hospitals)	2010	To assess existing facilities and gaps in the infrastructure and human resources available at the secondary level public hospitals (district, *taluk* and non-*taluk* hospitals) in TN.	Inadequacy in human resources was found particularly in *taluk* and non-*taluk* hospitals. Limited or no equipment existed in some. Essentials, such as electricity and water were lacking in few hospitals.	The state health system took many efforts to address the gaps in the facilities and there has been a tremendous improvement in the system.

APPENDIX G. PPP CASE STUDIES

PUBLIC-PRIVATE PARTNERSHIP EXAMPLES



PARTNERSHIP	AROCKIA HEALTH CENTER
OBJECTIVES	Ensuring comprehensive health care with a focus on HIV/ AIDS for industrial workers/migrants and truckers associated with the industries.
PARTNERS	Ashok Leyland TANSACS APAC-VHS RID
HOW THE ALLIANCE WORKED	This project was piloted in Hosur town as well as the surrounding 15 kilometers, including the stretch between Ashok Leyland Plant I and Ashok Leyland Plant II. The partners developed key strategies to achieve the following goals and objectives: BCC (Arockia Health Center, including IPC and events) Quality STI care and treatment and follow-up Condom promotion Creating an enabling environment Community mobilization and peer education Promotion of voluntary CT Care and support services for PLWHA among the target groups Networking and leveraging of resources The project also generated demand for health services at the Arockia Center through press releases, press and media support, poster display, IEC distribution, meeting with collaborating with organizations, wall writings, BCC events, and promotion and referral through outreach workers/PEs. Ashok Leyland communicated with all industries and offered referrals to other NGOs and Hope Trust; support and referrals from secondary target groups; and medical/mobile health camps.

PARTNERSHIP	AROCKIA HEALTH CENTER
PARTNERS CONTRIBUTIONS	TANSACS Provided free testing kits and condoms Support in advocacy Issue of orders to industries in Hosur town District level communication campaign ASHOK LEYLAND Overall coordination and implementation of the project. Financial support for establishing and managing the Arockia clinic. Including positioning of staff, medical officer, nurse, medicines and other recurring expenses. Maintenance of ambulance, including repair, tires, etc. Provided budget/support to RIDS for all positions as agreed upon. Coordinated with the district administration. Conducted quarterly meetings. Advocated with other industries, officials, and organizations. Shared information with all partners. Overall monitoring of activities and sharing reports. Recognized the best contributors. Hired two officers on part time basis to monitor the project. Positioned the CSR field officer as in-charge of the project. APAC-VHS-USAID Sponsored two ORWs Supported capacity building for 40 PEs Trained the outreach team, sponsored by APAC and Ashok Leyland Developed exhibition panels to place in the Arockia clinic. Provided IEC material. Participated in quarterly review meetings Provided technical consultancy 10 days annually Provided technical support to develop systems and protocols and to document best practices Designed brochure for Arockia Health Center as part of the PPP launching function Organized a training program for counselors on family counseling and HIV/AIDS Offered TS for branding of Arockia Health Center DISTRICT ADMINISTRATION (Krishnagiri District) Sponsored a place for conducting Arockia clinic Conducted meetings with industrial owners' association Advocate for initiatives, press and media coordination Ensured special services for PLWHA Ensured the support of health department officials RIDS Facilitated outreach and monitoring Demanded generation of and linkage with services Conducted capacity building, advocacy and related activities

PARTNERSHIP	AROCKIA HEALTH CENTER
BEST PRACTICES/LESSONS LEARNED	This PPP demonstrates APAC's capability to bring core partners together; foster strong trust and confidence between partners; and leverage significant resources in order to achieve project goals. Building strategic partnerships with corporations ensures longer term buy-in and resource commitments. It is noteworthy that the leveraging ratio between APAC and Ashok Leyland was 1:8, which sets a high standard for PPP leveraging.

APPENDIX H. IEC MATERIALS CREATED BY THE PROJECT

Care and Support & Treatment

USAID
FROM THE AMERICAN PEOPLE

AIDS PREVENTION AND CONTROL (APAC) PROJECT,
VOLUNTARY HEALTH SERVICES (VHS),
T.T.T.I Post, Adyar, Chennai - 600 113. Tamil Nadu, India.
Ph : 044 -2254 1048 / 044 2254 1965. Fax : 044 -2254 2018
e-mail : apacvhs@eth.net Website : www.apacvhs.org

APAC-VHS

Game and puzzle based communication

AIDS PREVENTION AND CONTROL (APAC) PROJECT,
VOLUNTARY HEALTH SERVICES (VHS),
T.T.T.I Post, Adyar, Chennai - 600 113. Tamil Nadu, India.
Ph : 044 -2254 1048 / 044 2254 1965. Fax : 044 -2254 2018
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APAC-VHS

INNOVATIONS

USAID
FROM THE AMERICAN PEOPLE

AIDS PREVENTION AND CONTROL (APAC) PROJECT,
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APAC-VHS

For more information, please visit
http://www.ghtechproject.com/resources.aspx

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