INDIA - CANADA COLLABORATIVE HIV/AIDS PROJECT

FINAL DRAFT PROJECT IMPLEMENTATION PLAN

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TABLE OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
AWP	Annual workplan
CBO	Community-based organization
CEA	Canadian executing agency
CHC	Canadian High Commission
CIDA	Canadian International Development Agency
FSW	Female sex worker
GOC	Government of Canada
GOI	Government of India
HIV	Human immunodeficiency virus
IAS	Indian Administrative Service
IDU	Injection drug user
IEC	Information, education and communication.
KSAPS	Karnataka State AIDS Prevention Society
LFA	Logical framework analysis
NACP- I, II	National AIDS Control Programme (Phase I and II) of India
NACO	National AIDS Control Organization (of India)
NGO	Non-governmental organization
PIP	Project Implementation Plan
PMF	Performance Measurement Framework
PLWHA	Person living with HIV or AIDS
RBM	Results-based management
RMF	Risk Management Framework
RSACS	Rajasthan State AIDS Control Society
SACS	State AIDS Control Society
SAPO	State AIDS Program Officer
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TRG	Technical Resource Group
UNAIDS	Joint United Nations Programme on AIDS
WBS	Work breakdown structure
WHO	World Health Organization

1. INTRODUCTION AND BACKGROUND

1.1 DEVELOPMENTAL CONTEXT

1.1.1 Development indices

India, with the second largest population in the world (estimated at 966.2 million in 1997), ranks 132nd out of 174 countries on the Human Development Index (HDI), placing it at the lower end of the medium category on this scale[1]. The HDI is constructed from life expectancy at birth, adult literacy rate, combined gross school enrolment ratio and real gross domestic product (GDP) per capita. Life expectancy at birth in India has risen from 49.1 years in 1970 to 62.6 years in 1997, with 83.9% of the population now expected to live beyond 40 years. The adult literacy rate is 53.5% and the national school enrolment rate in 1997 as a percentage of relevant age group was 77.2% for primary school and 59.7% for secondary school. GDP in 1997 was U.S. $381.6 billion, with agriculture contributing 25%, industry 30% and services 45%. The GDP per capita in 1996 was $465, up from $250 in 1976 as a result of an average annual rate of change of 3.0%.

India ranked 112 on the gender-related development index (GDI) in 1997. This index uses the same variables as the HDI, but adjusts the average achievement of each country in life expectancy, educational attainment and income in accordance with the disparity in achievement between women and men. Comparative figures for women and men in 1997 in India were 62.9 and 62.3 years for life expectancy at birth, 39.4% and 66.7% for adult literacy, 47% and 62% for combined first-, second- and third-level gross school enrolment ratio, and $902 and $2389 for real GDP per capita, expressed as purchasing power parity.

1.1.2 Economic situation

Gross national product (GDP plus net income received by residents from abroad for labour and capital after deductions for payments made to non-residents who contribute to the domestic economy) was $357.4 billion, or $370 per capita in 1997. The Gross National Product (GNP) per capita annual growth rate between 1975 and 1995 was 2.8%, as the overall annual growth rate of 5% was tempered by significant annual population growth. This was 2.0% in 1975 when the population was 670 million and slowed to 1.3% by 1997. Annual public education expenditure in 1996 represented 3.4% of GNP and 11.6% of annual total government expenditure for the period 1993-96, with health expenditure representing 0.7% and military expenditure 2.5% of GDP in 1996. Annual inflation averaged 9.0% over the 1985-96 period and was 6.3% in 1996. Over the last decade India has reduced its reliance on foreign aid from $2,745 million in 1991 (1.1% of GDP) to $1,678 million in 1997 (0.4% of GDP). However, external debt has risen from 19.2% to 24.9% of GDP over the same period. Debt service as a percentage of exports of goods and services fell from 22.7% in 1985 to 19.6% in 1997.

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[1] United Nations Human Development Programme (UNDP). *Human Development Report 1999*. New York: Oxford University Press, 1999.

1.1.3 Health Status

India's health profile, using latest available data for the period 1990-97, reveals 33% of infants with low birth weight, 96% of one year olds fully immunized against tuberculosis and 81% against measles. Infant mortality was 71 and under-five mortality 108 per 1000 live births. There were 53% of children who were underweight at age 5 years, there was a total fertility rate of 3.1, 88% of women were anemic in pregnancy and maternal mortality was 570 per 100,000 live births. Of the 1.2 million deaths per year in the 15-45 age group, an estimated 10 to 40% are believed to be HIV-related. The Government of India (GOI) estimates that 3.5 million people are infected with HIV and that 14 million people have tuberculosis, the most common illness among those who are HIV-infected in India. It was estimated in 1993 that by the end of the year 2000 the HIV epidemic will have cost India $11 billion in both direct medical costs and indirect costs due to the loss of productive labour. More recent work has shown that it will take India nearly one year longer to reach the HDI level it would have been expected to reach by the year 2005 as a result of the HIV epidemic[2].

1.1.4 Poverty and Gender

A 1997 World Bank report on HIV/AIDS[3] stresses the inter-relationship of premature death and poverty, and the importance of integrating anti-poverty and HIV mitigation programs. India ranked 59th on the human poverty index in 1997, with significant proportions of the population without access to safe water (19%), health services (25%) and sanitation (71%). India's vulnerability to HIV as a result of poverty is compounded by the unequal status of women. India ranks 95th on the United Nations gender empowerment measure, which is constructed from indices of economic participation and decision-making, political power and decision-making, and power over economic resources. Women in India hold 8.3% of seats in parliament, 2.3% of administrative and managerial posts, and 20.5% of professional and technical posts. The female economic activity rate in India was 50.3% of the male rate in 1997, reflecting gender disparity in women's opportunities to supply labour for the production of economic goods and services. Women's lack of power over economic resources translates into decreased control over sexual decision-making, which is so critical to protection against sexually transmitted infections (STI) and HIV infection. As well, the HIV epidemic carries disproportionate opportunity costs for women as a result of their traditional roles as caregivers and nurturers of the ill and dying. Addressing poverty and gender inequity will be essential to the success of India's HIV programming.

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[2] *The Looming Epidemic: The Impact of HIV and AIDS in India.* Godwin, P (ed). New Delhi: Mosaic Books, 1998.

[3] The World Bank. *Confronting AIDS: Public Priorities in a Global Epidemic.* New York: Oxford University Press, 1997.

1.2 PROJECT RATIONALE

1.2.1 HIV/AIDS in India

As suggested from the above, there is an urgent need to reduce the spread of HIV infection in India. Out of an estimated 31 million people currently infected with HIV worldwide, it is estimated that about 3.5 million live in India. Between 1994 and 1997, the prevalence of HIV infection among adults in India is believed to have more than doubled. In response to this rapidly growing epidemic, the Government of India is mounting efforts to address both its immediate and underlying causes. Accordingly, the GOI, through its National AIDS Control Organization (NACO) has developed a Second National AIDS Control Project (NACP-II). The key broad objectives of the NACP-II are to:

1) reduce the spread of HIV infection in India; and

2) strengthen India's capacity to respond to the HIV/AIDS epidemic on a long term basis.

To achieve these objectives, the NACP-II is designed to apply a strategic, integrated effort at the national, state and local levels. The principal strategy in NACP-II is to reduce HIV transmission within population subgroups with a high risk of acquiring and transmitting HIV infection and to prevent transmission of HIV from such groups to the general population. This effort will be complemented by interventions aimed at protecting population groups that are vulnerable to HIV infection and AIDS, and enhanced provision of care and support for those affected by HIV/AID.

1.2.2 Response by Canada

The Canadian International Development Agency (CIDA) has recognized the enormous humanitarian and developmental impact of the HIV epidemic in India and has committed to provide assistance to India by increasing the capacity of national, state and local institutions and agencies with a five-year project that is intended to complement the efforts of the GOI and state AIDS societies as they implement the NACP-II. The main focus of the project will be to provide specific support to the states of Karnataka and Rajasthan. These states were chosen through consultation with NACO. In addition, certain capacity strengthening activities will be undertaken at the national level with NACO and designated Technical Resource Groups (TRGs).

Through a competitive selection process, a consortium led by the University of Manitoba, Winnipeg, in collaboration with Mascen Consultants Inc., Ottawa, and ProAction: Partners for Community Health/Partenaires Pour La Santé Communautaire, Montréal, was selected by CIDA in June 1999 as the Canadian Executing Agency (CEA) to design and deliver a bilateral HIV/AIDS Prevention and Control Project in India.

A contract between CIDA and the University of Manitoba was signed in September 1999, and is to be executed in two phases: a Design Phase and an Implementation Phase. The Design Phase started upon signing of the contract. The major activity in this Phase has been for the CEA to undertake a Design Mission to India to work with the National AIDS Control Organization (NACO), some of NACO's Technical Resource Groups (TRGs), the state level AIDS societies

of Karnataka and Rajasthan, and their implementing partners, to develop a detailed design for the Implementation Phase. The project duration is planned to be five years and the implementation target date is six months after submission of a satisfactory Project Implementation Plan to CIDA and the Government of India, expected to be submitted in February 2000.

1.3 GENDER ANALYSIS

1.3.1 Gender and HIV/AIDS Prevention and Care

India's HIV epidemic is characterized by its heterogeneity. It continues to be strongly driven by heterosexual transmission, with HIV infection moving beyond its initial foci among female sex workers (FSWs) and their clients into the wider population. At the same time, there are important sub-epidemics evolving with potentially explosive spread among injecting drug users and men who have sex with men. Of the approximately 3.5 million people who are currently infected with HIV in India, about 75% are men and 25% are women, reflecting among other things, the tolerance of male access to sex beyond the marital relationship. Among men, HIV is concentrated in vulnerable populations such as truck drivers, migrant workers and the clients of commercial sex workers. Among women, HIV is concentrated among FSWs. In Mumbai, an estimated 60% of these women are HIV infected. As the epidemic continues however, there is a shift to women who are not FSWs. Recent surveillance data shows a 2% seroprevalence in antenatal women in certain sites, with an accompanying increase in pediatric HIV infection. Nearly half of all infections to date have been in the 15-24 year old age group, with the peak age of infection lower in girls than in boys. It is anticipated that women's biological, epidemiological and social vulnerability will greatly intensify this shift over time. The social and customary controls over women's social and sexual behavior that protect them from infection in an early epidemic will also render them vulnerable, as more and more of their male partners become infected.

1.3.2 The Status of Men and Women in India

The health of Indian women and men is intrinsically linked to their status in society. The contributions that women make to families are often overlooked, and instead women are often regarded as economic burdens. There is a strong son preference in India, as sons are expected to care for their parents as they age. This son preference, in combination with high dowry costs for daughters, sometimes results in the mistreatment of daughters. The most chilling evidence of this is the large number of "missing women" (i.e. girls and women who have apparently died as a result of past and present discrimination, for example, female feticide and infanticide, high maternal mortality and dowry deaths). Recent estimates place this number at approximately 35 million. Further, Indian women have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of, first, their fathers, then their husbands and finally, their sons. Women comprise approximately 70% of the poorest sectors of Indian society, and most of these women are heads of households.

India constitutes a challenging but nonetheless positive environment for promoting gender equality in the HIV/AIDS arena. NACO has recognized the importance of reaching marginalized groups such as female sex workers through peer-led initiatives within non-governmental organizations (NGOs). Furthermore, within both the governmental and non-

governmental sectors, a strong commitment to the empowerment of women exists. This is reflected in the adoption of key governmental policy documents. These include the National Perspective Plan for Women (1988) and the National Policy for Empowerment of Women (1996). Within the various five-year Plans therein, key commitments to women's issues were incorporated. These include the reservation of one-third of seats for women on all institutions of local governance within the Eighth Five Year Plan (1992-97) and the inclusion of the empowerment of women as one of the stated objectives of the Ninth Five Year Plan (1997-2002). In addition, unlike many developing countries, India has a number of existing and newly emerging gay rights and support groups.

1.3.3 Gender and HIV in India

The gender-related vulnerability of men and women to HIV infection in India can best be understood as constructed by and operating within a set of roles and norms that may differ between class, caste, tribe, religion and geographic area, but nevertheless exists within each of these. Access to and control over resources is profoundly gender-related in both the private and public domains. Concepts of appropriate expressions of masculinity and femininity in men and women are seen to be natural expressions of biological sex. How we understand both men and women's vulnerability to HIV infection requires a negotiation of the complex arena of gender roles, expectations, rights and responsibilities. This is equally true of access to care and support. Understanding gender norms and expectations for both men and women is crucial for promoting safer sexual practices in both high risk encounters and with regular sexual partners.

In India, as elsewhere, women are particularly at risk of STI and HIV infection for a variety of economic, biological and cultural reasons. As with other disenfranchised groups, women lack control over and access to the material and social resources that can assist them in avoiding STI/HIV infection. For example, 70% of those below the poverty line in India are women. Women are also more prone to HIV for biological reasons. HIV transmission during sexual intercourse is significantly more efficient from men to women than from women to men. Furthermore, it is known that the presence of STI significantly increases the likelihood of HIV acquisition. Unfortunately, many women with STI remain untreated for long periods of time because they may be asymptomatic or have limited access to health services, or because cultural taboos make it impossible for them to attend an STI clinic.

In addition to these factors, young girls and women in India are often at high risk owing to early marriage traditions, child prostitution, temple/caste-based prostitution, and where older men have sexual relationships with younger women. Women's vulnerability to HIV infection is exacerbated by the fact that the most effective means of prevention currently available require the active cooperation of men. Prevention strategies that emphasize male condom use, sticking to one partner or practicing non-penetrative sex are partner-dependent. As such, these strategies do not represent viable options for the many women who are denied the right to refuse sex or who are in a social, economic or cultural context that undermines their ability to insist on safer sex.

The socio-economic factors that are widely recognized as constructing women and men's vulnerability to HIV infection are often regarded as requiring long-term measures to redress, and consequently may be regarded as outside the domain of traditional STI/HIV prevention

programs. However, emerging knowledge demonstrates that even well-executed intervention programs fully supported by available, affordable and accessible condoms will have limited success in the absence of strategies to address the contextual determinants of behaviour change. For women, contextual determinants include fear of domestic violence, financial dependence on an unfaithful/infected partner, oppressive legal frameworks, lack of physical mobility and a (perceived) lack of other options. For gay or transsexual men, contextual determinants include fear of violence and social ostracism, oppressive legal frameworks and virulent stigmatization.

This is not to deny the necessity or efficacy of well-designed peer-led targeted interventions among vulnerable populations. These are both logical and needed. Promoting partner reduction, condom use and STI treatment in high-risk situations will make an extremely valuable contribution to slowing the progression of the HIV epidemic. However, vulnerable individuals (sex workers, clients of sex workers, men who have sex with men) do not lead isolated lives. For example, sex workers have children and husbands or lovers, sex workers' clients have wives and families, men who have sex with men also have wives and families. Behaviour change strategies that work for high-risk encounters may be inappropriate for relationships outside of this arena. Integral to the successful promotion of responsible, affirming sexuality and protecting against its opposite, is an understanding of how gender operates in people's social and sexual lives. Therefore, in order to promote comprehensive, sustainable HIV prevention strategies and better care and support, HIV prevention and care programs must include both a greater understanding of gender and HIV, not reinforce gender stereotypes and promote equal access for all to services, commodities and information. This must be complemented by simultaneously working with development and social change organizations, for example, organizations working for positive legal frameworks, credit programs for women or increasing access for girls to education.

1.3.4 Men and Women's Experiences of HIV/AIDS

Regardless of social class or gender, AIDS is a chronic disease that brings multiple episodes of acute, serious illness. HIV brings together the taboo subjects of sex and death, and shines an unwelcome light on people's most private behaviour. It has almost a unique potential to provoke fear, misunderstanding, misery and victimization. The following observations will give some idea of men and women's lived experiences with HIV/AIDS and highlight some ways in which HIV is experienced differently by men and women. These observations are drawn primarily from personal interviews and observations of the project Design Team and a recent unpublished study entitled *HIV/AIDS Related Discrimination, Stigmatization and Denial in India*, by Shalini Bharat, Tata Institute, 1999. In this study, 46 HIV positive people in Mumbai and Bangalore were interviewed. A majority of the men were married, whereas most of the women were widowed. Most of the participants were from lower and lower middle socio-economic sections of society. While there were many examples of exemplary service provision for individuals with HIV infection, in common with many countries responding to a newly emerging HIV epidemic, the quality of service delivery and attitudes varies considerably.

Generally speaking, most people's first point of contact with knowledge of their own or their spouse's HIV status is in the health care setting. Quality HIV counselling and testing services are unevenly available and test results are often not accompanied by appropriate counselling. In many instances, both men and women's HIV results are first disclosed to their families. Sex workers are particularly stigmatized in public hospitals, often preferring to go for private care.

For many brothel based sex workers in India, home-based care is not an option, when home is a brothel, and ties to family and community have been severed. According to the Tata Institute report, most public hospitals are struggling to provide quality medical care. Attempts are made to minimize contact by wearing gloves, keeping clothes separate, feeding/treating HIV positive patients last, etc. In the private sector, it is common practice for doctors to refuse to treat HIV positive patients, but to refer them to a public health facility. There may be significant discrimination against women in the home setting as well, as they are vulnerable to their families-in-law for care and support. They may be blamed for their husband's infection, and denied medical treatment or a share in their husband's property.

Both Indian men and women's experience of being HIV positive is often painful and stigmatized. It is also profoundly influenced by gender. Sexually acquired HIV, which by its nature reveals sexual relationships beyond mutual monogamy, is highly stigmatized, and the degree of stigmatization appears to be proportionate to both the degree of illicit behavior and challenges to accepted gender norms revealed. It is important to note that at this point in the epidemic in India, it is primarily socially and economically vulnerable people who are infected, and given the fact that the middle and upper classes often access health care through the private health care system, very little is known about their experiences.

According to available data, three times more men than women have HIV in India. Men's role as breadwinner, the large numbers of migrant male workers and truck drivers spending long periods of time away from home, control over disposable income, and a degree of societal expectation and tolerance of extra-marital relationships for men has placed them at high risk of HIV infection. Furthermore, homosexuality is extremely stigmatized. Gay men are hard to reach and so stigmatized that they often choose an HIV positive identity while continuing to deny their gay identity.

Women are vulnerable to HIV infection and inadequate care and support in different ways. The majority of HIV positive women are sex workers. Such women belong to an already stigmatized group and this stigmatization is compounded by HIV infection. Women who become sex workers pay a high price in social cost. Extremely high levels of HIV, resulting in a double stigmatization, now compound this. As indicated above, many HIV positive pregnant women are vulnerable to termination of pregnancy or refusal of a health facility to admit for delivery. Married or widowed HIV positive women are often blamed for their husband's infection and vulnerable to inadequate care by their families-in-law.

1.3.5 Key Pertinent Issues

Based on the forgoing, some key issues should be borne in mind when considering HIV/AIDS and gender equality in India. These include:

- Men and women are currently HIV infected in a ratio of 3:1, but this ratio is expected to shift over time as more women become infected.
- Vulnerable men and women are currently bearing the brunt of HIV infection, but there are indications that HIV is spreading into the "general" population; for example, recent surveillance rounds indicate up to a 2% seroprevalence in certain antenatal populations.

- The existing male to female HIV infection ratio requires both current and anticipatory responses. Current responses are needed to address the particular vulnerability of men and sex workers and anticipatory responses are needed to address the shift in infection to women more broadly.
- There is a high degree of association between female sex workers, men who have sex with men, truck drivers and other vulnerable groups and HIV infection. People outside of these defined groups do not see themselves at risk.
- STI/HIV in India is highly stigmatized. This negatively affects the availability of and access to quality STI/HIV prevention and care services.
- Bridging the gap between the uncharted domain of men's private behaviour and women's powerlessness is one of the major cultural and political challenges posed by the HIV epidemic in India.
- Sex workers' and married women's access to HIV-related care is highly variable. Home-based care for sex workers who are brothel-based or for married women living with their in-laws is often problematic.
- In Karnataka and Rajasthan, a vast range of sex work exists. It includes child prostitution, temple prostitution (*devadasi*), brothel, home bar-based and caste-based prostitution, and men who have sex with men. Thus, multiple intervention strategies will be required, based on a peer-mediated education approach.
- The stigmatization of gay and bisexual men and transsexuals make them particularly vulnerable to HIV infection, and render it both difficult and urgent to reach and support them for HIV prevention and care.
- Linking STI/HIV services with development and human rights initiatives will be central to providing a continuum of prevention and care for poor people.
- A dearth of information exists regarding HIV infection and sexual behaviour in India. A key component of any STI/HIV prevention and care strategy must be the gathering of reliable biomedical and behavioural gender-specific information.

1.4 Lessons Learned from Similar Activities and Previous Experience

India is facing a potentially devastating HIV/AIDS epidemic, but is in a position of being able to benefit from experience in other countries, particularly in sub-Saharan Africa and Southeast Asia. Almost two decades of HIV/AIDS programming has demonstrated that some strategies are highly effective in reducing HIV transmission while others have very little short-term impact. NACP-II is designed to implement these strategies as widely as possible, through state and municipal corporation AIDS Societies, and their NGO and other implementing partners. These intervention strategies are directed at proximate and remedial causes of the HIV/AIDS epidemic. Worldwide, the underlying causes of HIV epidemics are the same: marginalization, poverty and inequity. These in turn lead to behaviour and circumstances that result in HIV transmission. While resolving these underlying causes is an important goal and may be the ultimate solution to the epidemic, they cannot all be achieved in the time needed to prevent a catastrophic HIV/AIDS epidemic in India. However, over the past 20 years a number of highly effective interventions, capable of reducing HIV transmission by 40-80%, have been developed. These interventions

utilize what may be called the "classic" public health response to epidemics, have a solid theoretical basis and evidence for their effectiveness is drawn from observational studies or intervention trials.

The classic public health response addresses factors in the HIV epidemic that are rapidly amenable to intervention. It first includes identifying proximate causes of HIV spread. For HIV in India these include unprotected heterosexual sex, particularly in the context of the sex trade; unprotected sex among men who have sex with men; a high prevalence of treatable bacterial sexually transmitted infections; and sharing or reuse of needles for injecting drugs. The second element includes identification of demographic, ethnographic and geographic "hot spots" for HIV transmission. The third element involves designing and implementing interventions, based on what has been shown to work from experience or from intervention studies, targeting the communities or populations groups and the behaviour or conditions that put people at risk of HIV. From the world-wide experience, there are at least six strategies that have been shown in observational studies or trials to be highly effective in reducing risky behaviours and/or HIV transmission. These are:

- Peer-mediated group education and condom promotion among female sex workers.
- Peer-mediated group education and condom promotion among men at risk of HIV.
- Voluntary HIV counseling and testing.
- Needle exchange and other harm reduction strategies among injection drug users.
- Provision of effective STI management services to the general population.
- Antiretroviral prophylaxis and breastfeeding alternatives for the children of HIV infected women.

Each of these interventions is cost-effective when compared to public health interventions for other health problems. It is important to note though that these interventions are not formulaic. They must be responsive to the needs of the target population and undertaken in partnership with them at every stage. NACP-II is largely designed to apply this response to the HIV/AIDS epidemic in India. The project will work to enhance the capacity of NACO, the TRGs, RSACS and KSAPS to do this in two main ways: first by enhancing their capacity to mount effective interventions and second by assisting them in the development of new effective intervention models.

Global experience has also provided several broad lessons learned on the manner and the context required for effective implementation of HIV prevention interventions. For targeted interventions to be effective, they must be undertaken in a manner such that they empower the groups involved in the intervention. In fact, they will predictably fail if they do not. While there is always a real concern that targeting already disadvantaged groups will stigmatize and further marginalize them, if undertaken correctly, these interventions can be tremendously empowering. The best interventions become a spark for community development, as has been seen with the Sonagachi project in Calcutta, the University of Manitoba/University of Nairobi work in Kenya and many other examples. Marginalized and disenfranchised people who are shown how to take control over one measure of their lives, soon begin to look for other ways to change their lives.

The project will work extensively with its partners to ensure that the interventions undertaken maximize empowerment of the target communities.

To succeed, targeted interventions must be undertaken within an environment that enables the interventions to occur without fear or prejudice. This means that there needs to be a significant understanding of the issues involved within the general population to counter attitudes that may undermine interventions. There must also be an appropriate policy framework in place. For example, it will do little good to educate sex workers about HIV and condoms if they are being harassed and arrested by the police. This requires continuous and effective public education, education and training of health workers, partnering with social change and development initiatives, and continuous advocacy with political leadership.

Finally, prevention and care are part of a continuum. Prevention programs cannot achieve their potential if there is no capacity for care of those with HIV infection and AIDS. As the numbers of people who are ill with AIDS continues inexorably to rise over the coming years in India, it will be important to mobilize communities to respond to the care and support needs of those who are infected and affected. There must be an environment created where people can see that disclosure of a positive HIV status can result in continued employment, active community involvement without discrimination, counselling for positive living, support from others with HIV and comprehensive health care (acute, out-patient and home-based). Otherwise, few people will come forward for testing, and valuable prevention opportunities will be lost. Those HIV-infected people who do not know their status are not able to plan for themselves and their loved ones, take steps to prevent transmission to sex partners and make informed reproductive choices. While NACP-II emphasizes interventions among those who are at highest risk of transmission of HIV, it does not ignore individuals with lower risk or individuals with HIV-related disease or AIDS. General education and information programs for lower risk individuals are undertaken as a necessary adjunct to high risk group interventions. Also, cost-effective treatment for opportunistic infections, defined as those that prolong life or prevent secondary transmission, are provided for individuals with AIDS. The project will work with its partners to develop demonstration projects for a continuum of care from voluntary counseling and testing to effective home-based care.

2. DESIGN CRITERIA

2.1 PROJECT GOAL AND PURPOSE

2.2 PROJECT GOAL AND PURPOSE

As per the terms of reference provided by CIDA and NACO, the goal of the project is to contribute to India's efforts to slow the progression of the HIV/AIDS epidemic and to mitigate the impact of the epidemic on vulnerable individuals and groups.

The purpose of the project is to strengthen the institutional capacity of the Karnataka and Rajasthan state AIDS societies and their implementing partners, as well as NACO and selected Technical Resource Groups, to plan, design, implement and evaluate initiatives related to the Government of India's National AIDS Control Project – Phase 2 (NACP-II).

2.3 EXPECTED OUTCOMES

The expected project outcomes are:

- Slowed progression of the STI/HIV epidemic among women and men in project areas, contributing directly and indirectly to poverty reduction, and to gender equality.

- Mitigation of the impact of the HIV/AIDS epidemic among women and men in project areas, contributing directly and indirectly to poverty reduction, and to gender equality.

3. DESIGN METHODOLOGY

3.1 DESIGN TEAM COMPOSITION

As accepted by CIDA, the Design Team was composed of the following individuals.

Dr. Stephen Moses, University of Manitoba – Design Team Leader/Specialist in sexually transmitted infection control for HIV/AIDS prevention and program evaluation.

Dr. Francis A. Plummer, University of Manitoba – Specialist in targeted interventions, HIV/AIDS related policy development and program evaluation.

Dr. James F. Blanchard –Specialist in epidemiology, HIV surveillance systems and public health approaches to HIV/AIDS prevention.

Ms. Áine Costigan, University of Manitoba – Specialist in gender issues, community development, NGO liaison and community HIV care.

Dr. Catherine A. Hankins, ProAction – Specialist in human resource development, capacity building, gender issues and HIV/AIDS care.

Mr. P. Tota Gangopadhyay, Mascen – Specialist in project design and results-based management.

In addition, the design team was supported and accompanied throughout the Design Mission by Ms. Sarada Leclerc, Health and Population Specialist, Asia Branch, CIDA, Canada, Mr. T. Sampath Kumar, Development Officer, Canadian High Commission, India, and Dr. Thomas Philip, HIV/AIDS advisor for the Canadian High Commission.

3.2 DESIGN PROCESS AND DESIGN MISSION ACTIVITIES

The Design Mission began at the beginning of November 1999, following preparatory work among the Design Team, NACO, CIDA and the Canadian High Commission in India in September and October.

Initial meetings were held in New Delhi with CIDA, the Canadian High Commission and NACO, to carry out a needs analysis and establish the strategy for the participatory design process to be carried out during the rest of the design mission. Meetings were held subsequently in New Delhi with representatives of multilateral and bilateral agencies involved in the HIV/AIDS field in India, including UNAIDS, WHO, the World Bank, UNICEF, UNDP, UNESCO, UNIFEM, USAID, DFID and AUSAID.

To understand better the roles and needs of selected TRGs, meetings were held with representatives of the National Labour Institute (TRG on workplace interventions, located just outside New Delhi), in Chennai with representatives of the Institute of Venereology (TRG on sexually transmitted diseases) and in Mumbai with representatives of Grant Medical College

(TRG on clinical management). After meeting with representatives of the latter two TRGs, opportunity was taken to meet with representatives of the Tamil Nadu State AIDS Control Society and the Mumbai District AIDS Control Society, as well as with several of their implementing partners. This included field visits to project sites.

From November 14 to 23, the Design Team divided into two teams to carry out project design work in Karnataka and Rajasthan. The main counterparts in the two states were the Directors of the Karnataka State AIDS Prevention Society (KSAPS) and the Rajasthan State AIDS Control Society (RSACS), and Design Team members were accompanied throughout their visits by representatives of the two societies, in particular the NGO advisors and the deputy directors. A variety of methods were used to assess needs and capacities, with a view to developing the project design. These included meetings with state AIDS society and other government officials; meetings with implementing partners, including NGOs and academic institutions; and field visits to project sites. Workshops were also held with stakeholders to discuss and develop the project design elements. The design strategies and components described below were reviewed during meetings with the two state AIDS societies at the conclusion of the state visits, and agreed to by all parties.

After returning to New Delhi, the Design Team integrated the various elements of the project design, and made a preliminary presentation to NACO on November 25. Following feedback and input from NACO, the project design was revised further, and a final presentation was made to NACO on November 30. Presentations and briefings were also made to the Canadian High Commission and to the key multilateral and bilateral donor agencies involved in HIV/AIDS programming in India. A listing of design mission meetings and reports is available.

4. OVERALL DESIGN APPROACH

4.1 DESIGN RATIONALE

On December 15, 1999, the Government of India officially launched the National AIDS Control Program, Phase II (NACP-II) funded by the World Bank and the Government of India. NACP-II is designed to decentralize HIV and AIDS control activities to newly formed State AIDS Societies and rapidly implement evidence-based interventions in priority areas. There is particular emphasis on vulnerable populations at high risk of acquiring and transmitting HIV and on cost-effective programming. The focus of NACP-II is based on the following logic. In the HIV/AIDS epidemic in the Indian context, there are many needs competing for resources. The Government of India's priorities are to first stem the spread of HIV and second mitigate the impact of HIV/AIDS on Indian society. In discussions between CIDA and NACO, it was agreed that the Canadian contribution to this effort should complement other NACP-II activities, have a programmatic focus on capacity- building and a geographic focus on the states of Rajasthan and Karnataka. Thus the CIDA-funded HIV/AIDS project will fit closely within the framework of NACP-II and within CIDA's objective of supporting the social and economic reform process in India through capacity building of institutions and government organizations.

India urgently needs effective interventions at national scale to slow the spread of HIV infection. To intervene effectively, the causes of the HIV/AIDS epidemic must be understood. Particular patterns of sexual behaviour and a high prevalence of facilitating STIs drive the HIV/AIDS epidemic, but these are proximate, not root causes. The contextual determinants of the HIV/AIDS epidemic are social and economic: poverty, gender inequity, caste inequity, disenfranchisement and inadequate health infrastructure. While these root causes must be recognized in HIV/AIDS programming, addressing them is a long-term, complex and uncertain prospect. If NACP-II were to focus on these root causes alone, the HIV/AIDS epidemic would progress more or less unabated while solutions for these underlying problems were sought. There are public health interventions that are highly effective in slowing the spread of HIV. These interventions, however, are less effective in the longer term without the incorporation of strategies for simultaneously recognizing and addressing the contextual determinants of the epidemic. Targeted interventions must, therefore, simultaneously address the constructs of vulnerability. If not, there is a significant likelihood that targeted interventions would continue in isolation and perpetuity. For instance, interventions for sex workers are much more effective if they include a significant element of empowerment, with strategies to address the fundamental gender issues involved, than if they have a strict health focus. This means that health promotion for sex workers is built on a program that recognizes and responds to their stated needs. This can be best effected by collaborating with groups and organizations involved in fundamental development and social change initiatives in HIV/AIDS programming, for example literacy programs, legal rights advocacy groups and micro-credit programs.

4.2 CROSS-CUTTING ISSUES

In the approach of the Design Team to the Design Mission and following discussions with stakeholders, several principles emerged which cut across the different elements of the design. These are:

- Sustainability.
- Integration with overall development.
- Addressing gender issues at every level.
- Creation of an enabling environment and destigmatization.
- Participation of People Living With HIV/AIDS (PLWHAs) and vulnerable groups in programming.
- Evidence-based grounding of programs.

4.2.1 Sustainability

This project is conceived as a capacity building project to complement the entire NACP-II effort, with a geographic focus on two states. Its main thrust is to equip those responsible for HIV/AIDS control in India with the skills necessary to respond effectively to the epidemic. There was strong sentiment within the Design Team and other participants in the design process (NACO, CIDA, RSACS, KSAPS) that the project should be integrated into the NACO/state AIDS society framework for several reasons. While project delivery might be considerably easier if the project operated independently of the state AIDS societies and worked directly with implementers, this would be unsustainable and largely ineffective in building capacity within the state AIDS societies. There would also be the danger of setting up an environment of rivalry or competition with the state AIDS societies if the project were to have a separate organizational structure. Furthermore, the reach of the project will be greatly extended by working within the state AIDS societies. Finally, NACO and the state governments are very concerned that bilateral projects be closely coordinated with their own. Thus the project was designed for maximal integration possible with the state AIDS societies, subject to the need for accountability of the CEA to CIDA, and efficiencies that may be achieved through sharing of resources between Rajasthan and Karnataka.

If the project is successful in building capacity, then this capacity will be in place to maintain programming efforts after the project ends. The Government of India is already covering most of the programmatic costs involved in HIV/AIDS prevention control activities, either directly or through its large World Bank loan, which will ultimately be India's responsibility to repay. By integrating project activities within NACP-II, and the state and local structures which are implementing NACP-II, there is every expectation that project activities will be sustainable in the medium and long terms.

4.2.2 Integration with Overall Development

The ultimate solutions to the HIV/AIDS epidemic are development, empowerment and social change. While this project cannot directly implement traditional development programs, it will

significantly address development in two ways. This is based on the recognition that (depending upon the speed of its progress in India), the HIV epidemic will be accompanied by a regression of many development gains (for example, life expectancy and girl child literacy), the impoverishment of public and private sector services (for example the health sector), the devastation of household and community resources, and an increase in old and young dependents. Furthermore, in order to avert the need for targeted interventions in perpetuity, the contextual determinants of HIV vulnerability need to be addressed as health promotion programs focus on marginalized and vulnerable populations.

It is important therefore to weave an overall development perspective and approach throughout the project. The intervention approaches promoted by the project will include development techniques (community participation, community partnership and empowerment). Interventions must be designed so that they recognize the needs of vulnerable communities beyond HIV/AIDS, are empowering, and become a spark for community development. This has been the experience in Sonagachi in Calcutta, where an initial narrow health focus among sex workers has expanded into a community development movement. This has also been the experience of the design team with female sex worker interventions in Kenya, where successful sex worker group formation helps to rekindle hope among extremely disenfranchised women and shows them that they can take control of their lives. This will mean that interventions include community partnerships, group formation, peer leadership training, advocacy for the rights and needs of vulnerable populations, and supporting them to undertake initiatives for their own development. Leadership representation from vulnerable groups within project decision-making mechanisms will also be fostered.

It is also important to work with agencies that are involved in community development or social change initiatives and build their capacity to incorporate effective HIV/AIDS programming/advocacy as part of a comprehensive set of development activities and services. This will enable the project to provide responsible referral services for HIV-affected communities. Furthermore, the potential to address the underlying causes of HIV vulnerability can best be addressed by linking with organizations working on development issues and social change. The same strategies and principles described above will be employed.

4.2.3 Addressing Gender Issues at Every Level

As discussed above, gender norms, relationships and roles, and the relative status of men and women at every level will construct both men and women's biological and social vulnerability to HIV infection. Gender issues will also impact upon HIV-affected men and women's access to equal care and support. Accordingly, this project will seek to understand and address gender concerns at every level. Gender issues will be reflected in project analysis and design, the dedication of human and financial resources, the implementation of research, prevention and care activities, in monitoring and evaluation, and in community and institutional partnerships.

While health promotion will provide the *raison d'être* for working with vulnerable or marginalized groups, their lives will be understood as operating within a set of gender relationships and assumptions that may render them vulnerable to HIV. Thus, sex workers' relationships with their children, clients, husbands/lovers, "madams" and business owners/procurers, or sex worker clients' relationships with their female/male sex worker

contacts, their wives/lovers, families and children, will all be explored as part of sexual health promotion activities. Equally, the contribution that gender roles and norms make to responsible, affirming sexuality (or not) will be explored. Gender issues will then be addressed in culturally appropriate ways with project partners.

4.2.4 Creating an Enabling Environment and Destigmatization

Experience from around the world has shown that an enabling environment must be in place for effective HIV/AIDS prevention and care programming. Policy and decisions makers must have accurate knowledge of HIV/AIDS issues and their solutions so that counterproductive policies and pronouncements are avoided. Community leaders and authorities must be engaged, with sensitivity to the requirements of effective interventions, and at least permissive in their actions towards people affected by HIV/AIDS and vulnerable groups. The population must have basic knowledge about HIV/AIDS and be sensitized to the special needs of vulnerable groups. Condoms must be available at the place and time that they are needed. The social milieu of vulnerable individuals must support their decisions about sexual behaviour. Appropriate resources must be in place to meet the demand for voluntary counseling and testing and HIV/AIDS prevention must be considered within the continuum from prevention to care. The project will work with the state AIDS societies and implementing partners to help ensure that these elements of an enabling environment are in place in each state and that work at the state level informs national programming.

Another dimension of an enabling environment must be destigmatization of AIDS. If people with HIV/AIDS are rejected and ostracized, their participation and the participation of vulnerable groups at risk for HIV infection will be limited. HIV/AIDS exposes hidden aspects in any society. It brings together the taboo topics of sex and death, and requires an unprecedented openness regarding these subjects to adequately understand and address HIV/AIDS prevention and care. AIDS has an almost unique potential to provoke the very reactions that are antithetical to an effective response: denial, fear, judgement, stigmatization and discrimination. This is especially true in nascent epidemics. Such responses drive the epidemic underground and make it difficult to reach vulnerable and marginalized populations with the prevention, care and support that they require. This project will seek to destigmatize HIV disease and those at risk of infection or already infected. The project will work with policy makers, service institutions, NGOs, and vulnerable and affected communities to promote a non-judgmental, non-stigmatizing approach in their HIV-related work. This will provide HIV vulnerable and affected people with the care and support that they require to adopt and maintain safer sex practices, to access quality HIV testing, and to live with HIV disease healthfully and positively.

4.2.5 The Involvement of People Living With HIV/AIDS and Vulnerable Groups in Programming

People living with HIV/AIDS (PLWHAs) have first-hand experiences of the problems that they face. They are the ones who have periods of ill-health, who struggle to provide for their families, who face hostility in the communities in which they live, and who try to hold down employment in the face of discrimination. The involvement of PLWHAs is therefore crucial for any HIV initiative. Throughout the world, as PLWHAs are supported and empowered, they have made immeasurable contributions to HIV prevention and care, both informing and complementing the efforts of policy-makers, researchers and program implementers. Cared for and mobilized,

PLWHAs provide a voice, a human face to the epidemic. They are integral to destigmatizing HIV, to effective peer-education and solidarity, and to prevention, care and support programs. Among HIV affected communities, the involvement of PLWHAs in HIV prevention and care activities promotes legitimacy and trust. PLWHAs can also identify their changing needs and provide the necessary leadership in expanding policy and program directions. This project will actively seek to promote the involvement of PLWHAs in all project activities according to their defined priorities.

Many of the same issues apply to members of vulnerable groups. Women who are sex workers or men who are their clients know their own needs far better than others can hope to. Partnership with them and their engagement in designing and delivering interventions for their peers has proven to be a key element in the success of interventions throughout the world. In India, sex work, sodomy and injection drug use are all illegal and stigmatized activities. Reaching communities of sex workers and their clients, men who have sex with men and drug users, creating a safe environment for them to meet and address their concerns, and promoting HIV protecting behaviour can best be achieved through discrete, non-judgmental, peer-led initiatives. In fact, maximum impact cannot be achieved without the input and leadership of marginalized or vulnerable groups in programs designed for their participation.

4.2.6 Evidence-based Grounding of Programs

To intervene effectively in India, resources must be directed at the problem in the most effective way. This means that geographic areas that are the most vulnerable should be targeted first, that the most vulnerable groups should be targeted first, that strategies that interrupt the most transmission should be employed first, and that the most cost-effective strategies should be employed. Relevant and accurate information is required to be able to direct intervention efforts in a cost-effective manner to the areas where they are most needed; good data are required to make good decisions. In the HIV/AIDS epidemic in India, there are many needs for interventions. These include HIV/AIDS awareness, targeted interventions, social change, overall development and the need for compassionate care of PLWHAs. Over the past two decades, a large body of experience in HIV/AIDS prevention programming has accumulated around the world. Some strategies have been shown to be highly effective in changing sexual behaviour and reducing HIV transmission, while others, particularly those that do not go beyond the creation of awareness, are ineffective. Data from observational studies, and from clinical and community trials have shown that community-based peer-mediated group interventions among sex workers and high risk men, voluntary counseling and testing, and the provision of effective STI management to the general population can result in 40-90% reductions in risky behaviour and STI/HIV incidence. A mix of evidence-based strategies will be employed in the interventions promoted by the project. The project will also rapidly incorporate new interventions emerging from innovative programming into the range of strategies incorporated into the interventions it is promoting.

The need for information or evidence goes beyond the requirement for knowledge about where to intervene, who to intervene with and how best to do it. It is also part of iterative programming: using lessons learned from the experience of implementation to improve the efficiency of interventions and maximize their impact. Continuous monitoring and evaluation of both process and results are needed to adjust programs to suit local needs and changing

situations. Quantifying impact is a critical step in dissemination of best practices within states and nationally, so that the reach of the project is maximized. A major focus of the project will be on building the capacity of state AIDS societies and their implementing partners to collect and use information in programming.

5. GENDER STRATEGY

5.1 INTRODUCTION

CIDA's India Program gender equality strategy document notes that "there is a challenging but positive environment for promoting gender equality in India". The HIV/AIDS arena provides an opportunity for addressing the often hidden aspects of men and women's sexuality in India. Implicit in HIV prevention and care is the necessity to address not only sexual health, but also sexuality *per se*. The challenges are immense and highlighted in the foregoing gender analysis. In addition, the project will be working largely in male-dominated sectors and institutions, or with partners who do not necessarily understand the importance of gender or who do not consider it a priority. Furthermore, given the stigmatized nature of HIV/AIDS and identified risk groups (sex workers, men who have sex with men, etc.) it will be challenging to ensure that such constituencies have a voice in project decision-making and regarding the services designed to meet their needs. Educating policy makers and service providers regarding gender and HIV will be of central importance to the success of the project. Equally important will be the selection of gender-sensitive or gender-open implementing partners. However, these challenges are mitigated by the determination of the Indian government to slow the spread of HIV, the existence of a strong civil society, and the recognition within government that partnership with NGOs and vulnerable groups is central to their HIV prevention and care objectives. The lack of biomedical and behavioural data at all levels provides a real opportunity to gather gender disaggregated information from the outset.

5.2 UNDERLYING PRINCIPLES

The following principles underlie the project's approach to gender equality:

- The promotion of equal benefit for both men and women from the policies and programs designed to prevent STI/HIV or to provide STI/HIV care and support.
- The recognition that gender-related issues to a large extent determine both the vulnerability of men and women to HIV infection and to access to care and support services.
- An appreciation that a gender analysis and strategy applies to both mixed and same-sex social and sexual relationships.
- The promotion of culturally appropriate, responsible, affirming sexuality for both men and women.
- An appreciation of the need to work with organizations committed to gender equality or at least open to learning about gender considerations.
- A commitment to the care and support needs of women and children.
- A commitment to not reinforcing gender stereotypes within project programs.
- A commitment to working with sex workers and other marginalized groups in a manner that promotes the empowerment of such groups and reduces stigmatization.

- The resolution to work with organizations addressing legal discrimination and human rights violations of groups such as sex workers, men who have sex with men and people living with HIV/AIDS.
- A recognition of the need to work with development and anti-poverty organizations.

5.3 GENDER STRATEGY

The project will seek to understand and address gender issues in a committed and quantifiable way at every level. This includes with respect to project design, formative and ongoing research, capacity building at national, state and local levels, policy development, program implementation, decision-making, budget allocations and performance indicators. The project will also ensure that adequate gender expertise is available both within the project and for its partners.

5.3.1 Project Design

Two gender experts were included in the project Design Team from the outset and multiple consultations were held in India with gender experts. Every effort has been made to address gender at each project level in a quantifiable, practicable way.

5.3.2 Formative and Ongoing Research

There is a dearth of information regarding STI/HIV-related issues in the project states of Karnataka and Rajasthan. One of the central activities of the project will be the generation of reliable information that can be used for both program planning and policymaking decisions. Such research will include biomedical and behavioural surveys of important constituencies and a review of STI/HIV health care provision in both public and private sectors. To the greatest extent possible, all research will be disaggregated by gender and will seek to understand gender issues within each sector or target group. For example, biomedical surveillance will be applied to both men and women, behavioural/attitudinal research will include both behaviour (number of sex partners, condom use, health seeking behaviour, etc.) and attitudes (to sexuality, to men and women, to their own behaviour, etc.). Research on health services will attempt to understand how gender attitudes operate among health providers and within health services.

5.3.3 Capacity-building at National, State and Local Levels

This project is primarily directed at capacity building at state and local levels. Enhancing the capacity of Rajasthan and Karnataka State AIDS Societies and their implementing partners to plan, implement and evaluate STI/HIV prevention and care programs in a manner that is evidence-based and technically sound is the project's main focus. Within this focus area, formative and ongoing research will be undertaken which in turn informs policy and program frameworks. Accompanying this effort will be the enhancement of capacity to plan and evaluate programs and services. Finally, the implementation of a range of prevention and care initiatives within defined geographic sites will be supported. In the context of the project, capacity building will include developing the ability of state AIDS societies and their implementing partners to address gender equality issues within their areas of responsibility. This may require gender training in gender issues for state AIDS societies and their implementing partners.

5.3.4 Policy Development

At the state level, within the policy arena, a focus will be maintained on the ways in which men and women are affected differently by STI/HIV, how this translates into service/program needs and how program and service delivery can be monitored for both men and women. This will require the existence of gender disaggregated data and the participation of people with expertise on gender issues on policy and decision-making committees.

5.3.5 Decision-Making/Management

Within the area of the project's direct control (such as project staff and Canadian technical assistance staff), every effort will be made to hire both women and men and to have both women and men represented on the Project Steering Committee. In addition, Indian gender expertise will be hired and made available to the project.

5.3.6 Program Implementation

With regard to the implementation of STI/HIV prevention and care programs and targeted prevention interventions, gender will be addressed in the following ways. Overall, the project will support a commitment to a greater understanding of gender and HIV. Negative gender stereotypes will not be used in project materials or approaches, and equal access to services, commodities and information will be promoted.

More specifically, access of women to services will be addressed wherever it is relevant, as will access to services of men. For example, within in the management of STI, if women do not attend STD clinics, then efforts will be made ensure that women are reached where they access health services (family planning clinics, gynecologists, private practitioners, etc.). Given the extent to which women are asymptomatic with STI, the idea of presumptive treatment for vulnerable women (sex workers) will be explored. Finally, opportunities will be sought to integrate STI/HIV education into established reproductive health education forums.

In the delivery of targeted interventions for vulnerable groups, the project will make every effort to work within an empowerment framework. Strategies to prevent STI/HIV transmission must be relationship-specific; strategies aimed at high-risk impersonal encounters are likely not appropriate for a more intimate arena. Therefore, targeted interventions will emphasize gender relationships in every aspect of the lives of vulnerable people and develop STI/HIV prevention strategies relevant to the continuum of impersonal/intimate sexual relationships.

With regard to the delivery of care in health facilities, every effort will be made to promote HIV testing that is based on informed consent, with pre- and post-test counseling. Health workers will be educated to be non-judgmental in their attitudes towards sex workers, gay and transsexual men, and HIV-infected men and women. Efforts will be made to ensure that pregnant HIV positive women have access to choice to continue with their pregnancy or not. Health facilities will be encouraged to admit HIV positive women for the delivery of their babies. With respect to home-based care, the project will seek to understand the extent to which men and women receive care and support in the home setting. Particular attention will be paid to brothel-based sex workers and HIV positive women living with their in-laws.

5.3.7 *Monitoring and Evaluation*

Gender-specific performance indicators will be developed for each key project area. It is important to emphasize that the project's gender strategy is iterative and will be adjusted as time and experience in the field provides new information and challenges. It is expected that the Project Steering Committee and CIDA review the project's gender progress on gender equality issues on an annual basis. It is also expected that the state AIDS societies will also regularly review the gender aspects of their work, including their work with this project.

5.3.8 *Budget*

Dedicated funds will be set aside where a need for gender training or positive discrimination is required. For example, gender training will be provided for state AIDS society staff and their implementing partners and in the arena of HIV/AIDS care, specific funds for the support of HIV positive women will be set aside.

6. LOGICAL FRAMEWORK ANALYSIS

The project's logical framework analysis is given in the table below. Detailed descriptions of the project's four components (Karnataka, Rajasthan, National and Management) are given in sections 7-10 that follow.

Project Title	**India-Canada Collaborative HIV/AIDS Project**	**Project Budget**	$12 million
CEA/Partner Organization	University of Manitoba, in association with Mascen Consultants Inc. and ProAction: Partners for Community Health	**Project Manager (CIDA)**	Sarada Leclerc
Related CPF	To support the social and economic policy reform process in India.	**CIDA Project Team**	

Logical Framework Analysis at Goal and Purpose Level

Narrative Summary	Expected Results	Performance Measurement	Assumptions/Risk Indicators
Project Goal (Program Objective) To support the social and economic policy reform process in India by strengthening the capacity of institutions and government organizations.	**Impact** Enhanced capacity of institutions and government organizations in India to formulate, promote and implement effective policies and programs on HIV/AIDS prevention, care and support, thus satisfying the basic human needs of the country.	**Performance Indicators** At the national and state levels: - Policies implemented to create an enabling environment for more effective HIV/AIDS prevention, care and support.	**Assumptions/Risk Indicators** - Continued government willingness to introduce and support social and economic reforms (Risk – Low).
Project Purpose	**Outcomes**	**Performance Indicators**	**Assumptions/Risk Indicators**
To develop the institutional capacity of the Karnataka and Rajasthan state AIDS societies, as well as their NGO and their implementing partners, as well as NACO and selected Technical Resource Groups, to plan, design, implement and evaluate initiatives related to the Government of India's National AIDS Control Project – Phase 2 (NACP-II).	1) Slowed progression of the STI/HIV epidemic among women and men in project areas, contributing directly and indirectly to poverty reduction, and to gender equality.	1.1) Increase in the prevalence of safer sexual practices among women and men in project areas. 1.2) Reduced prevalence of conventional STIs among women and men in project areas. 1.3) Reduced rate of increase in the prevalence of HIV infection among women and men in project areas.	- National and state level political commitment to HIV prevention and control continues (Risk - Medium). - Commitment of financial resources from the national and state governments continues (Risk - Low).
	2) Mitigation of the impact of the HIV/AIDS epidemic among women and men in project areas, contributing directly and indirectly to poverty reduction, and to gender equality.	2.1) Increased availability of high quality care and support services for HIV-affected women and men in project areas. 2.2) Increased sensitivity to the needs of HIV-affected women and men in project areas.	

Logistical Framework Analysis for Karnataka Component

Narrative Summary Resources At Karnataka State level:	Expected Results Outputs At Karnataka State level:	Performance Measurement Performance Indicators At Karnataka State level:	Assumptions/Risk Indicators At Karnataka State level:
K1000 Capacity Building for KSAPS and Implementers: - Technical assistance/mentoring. - Needs-based training. - International linkages and study tours. - Strengthening selected facilities. - Funding selected initiatives.	**K1100** Improved KSAPS and implementers' capacity to gather, analyze and integrate information into decision making.	- KSAPS is collecting and using evidence-based data in strategic planning of its activities. - KSAPS has established systems for monitoring and evaluating intervention programs. Increased number of implementers are: - Using situation analysis, community needs assessment and operational research prior to program formulation and implementation. - Monitoring and evaluating program outcomes and impacts.	- Commitment of human and financial resources by KSAPS to support the activities (Risk – medium). - Individuals, communities and institutions accept data gathering activities (Risk – low to medium). - Implementers willing to participate in project activities (Risk – low). - Financial resources are available to the implementers to carry out suggested activities prior to and during implementation of their program (Risk – medium).
	K1200 Enhanced KSAPS and implementers' capacity to mobilize, monitor and disseminate high quality HIV/AIDS prevention and care programs.	KSAPS and increased number of implementers are: - Using best practices in delivery of targeted programs. - Disseminating results and scaling up effective programs. - Establishing culturally sensitive voluntary counseling & testing. - Establishing STI management systems at local level. Increased number of implementers are: - Using innovative participatory peer group interventions with vulnerable populations.	- Commitment of human and financial resources by KSAPS to support the activities (Risk – medium). - Individuals, communities and institutions accept data gathering activities (Risk – low to medium). - Implementers willing to participate in project activities (Risk – low). - Financial resources are available to the implementers to carry out suggested activities prior to and during implementation of their program (Risk – medium).
	K1300 Enhanced KSAPS and implementers' capacity to create an enabling environment for HIV/AIDS programming.	- Community leaders and politicians are sensitized on HIV/AIDS issues; - Increased involvement of HIV- infected people in programming of initiatives and policy advocacy. - State level policies and programs ensure occupational health & safety of health workers, and continuum of prevention, care and support for HIV infected persons. - Effective and appropriate behaviour change communication materials are produced and delivered.	- State level policy-makers have supportive attitudes towards HIV infected persons (Risk – medium). - Community leaders are willing to listen (Risk – medium). - PLWHAs are willing to get involved in programming (Risk – low).

Narrative Summary	Expected Results	Performance Measurement	Assumptions/Risk Indicators
Resources	**Outputs**	**Performance Indicators**	
At District level:	**At District level:**	**At District level:**	**At District level:**
K2000 District level demonstration project: - Partnering with NGOs and other implementers. - Capacity building of implementing partners. - Technical assistance to implementing partners. - Formative research. - Impact evaluation. - Dissemination of innovations and results. - Needs-based training. - Strengthening of selected facilities. - Funding selected initiatives.	**K2100** Enhanced information base for HIV/AIDS policy, iterative programming and monitoring and evaluation (in demonstration project area)	- Project area selected, mapped and baseline information gathered. - Partnering with NGOs and other implementers secured. - Selected labs capable of HIV/STI diagnosis and surveillance. - Strategic plan for an integrated model of HIV/AIDS program developed. - Monitoring mechanisms established.	- Suitable community organizations for partnering are available (Risk – medium).
	K2200 Community-based participatory interventions for vulnerable and marginalized women and men (in demonstration project area).	- Implementing partners identified, trained and are effectively training peer educators. - vulnerable groups identified, baseline assessment completed and interventions implemented. - KSAPS and implementing partners carrying out, monitoring and evaluating programs in demo project area, disseminating results, training other implementers.	- State government supports project activities through funding selected interventions (Risk – medium to high). - Suitable implementing agencies available in demonstration project area (Risk – low).
	K2300 Enhanced accessibility to and quality of STI management (in demonstration project area).	- Baseline information collected on current STI management practices. - Strategic lab facilities upgraded. - Counseling, condom promotion, partner notification systems in place.	- Suitable and willing public or private providers are available in demonstration project area (Risk – low). - Suitable and upgradable laboratory facilities are available in demonstration project area (Risk – medium).
	K2400 Improved availability of high quality care and support for individuals and families affected by HIV/AIDS (in demonstration project area).	- Baseline information collected on current hospital and home-based care practices. - Number of care providers trained. - Care and support services improved in project communities. - Voluntary counseling and testing services established in selected sites. - Local PLWHA self-help groups established. - Local NGOs producing appropriate plans and proposals for community-based HIV care projects.	- Suitable NGOs are available and cooperative (Risk – low).

Logistical Framework Analysis for Rajasthan Component

Narrative Summary Resources At Rajasthan State level:	Expected Results Outputs At Rajasthan State level:	Performance Measurement Performance Indicators At Rajasthan State level:	Assumptions/Risk Indicators At Rajasthan State level:
R1000 Capacity Building for RSACS and Implementers: - Technical assistance/mentoring. - Needs-based training. - International linkages and study tours. - Strengthening selected facilities. - Funding selected initiatives.	**R1100** Improved RSACS and implementers' capacity to gather, analyze and integrate information into decision making.	- RSACS is collecting and using evidence-based data in strategic planning of its activities. - RSACS has established systems for monitoring and evaluating intervention programs. Increased number of implementers are: - Using situation analysis, community needs assessment and operational research prior to program formulation and implementation. - Monitoring and evaluating program outcomes and impacts.	- Commitment of human and financial resources by RSACS to support the activities (Risk – medium). - Individuals, communities and institutions accept data gathering activities (Risk – low to medium). - Implementers willing to participate in project activities (Risk – low). - Financial resources are available to the implementers to carry out suggested activities prior to and during implementation of their program (Risk – medium).
	R1200 Enhanced RSACS and implementers' capacity to mobilize, monitor and disseminate high quality HIV/AIDS prevention and care programs.	RSACS and increased number of implementers are: - Using best practices in delivery of targeted programs. - Scaling up effective programs and disseminating results. - Establishing culturally sensitive voluntary counseling & testing. - Establishing STI management systems at local level. - Increased number of implementers are: - Using innovative participatory peer group interventions with vulnerable populations.	- Commitment of human and financial resources by RSACS to support the activities (Risk – medium). - Individuals, communities and institutions accept data gathering activities (Risk – low to medium). - Implementers willing to participate in project activities (Risk – low). - Financial resources are available to the implementers to carry out suggested activities prior to and during implementation of their program (Risk – medium).
	R1300 Enhanced RSACS and implementers' capacity to create an enabling environment for HIV/AIDS programming.	- Community leaders and politicians are sensitized on HIV/AIDS issues; - Increased involvement of HIV- infected people in programming of initiatives and policy advocacy. - State level policies and programs ensure occupational health & safety of health workers, and continuum of prevention, care and support for HIV infected persons. - Effective and appropriate behaviour change communication materials are produced and delivered.	- State level policy-makers have supportive attitudes towards HIV infected persons (Risk – medium). - Community leaders are willing to listen (Risk – medium). - PLWHAs are willing to get involved in programming (Risk – low).

Narrative Summary	Expected Results	Performance Measurement	Assumptions/Risk Indicators
Resources	Outputs	Performance Indicators	
At Demonstration Area levels:	At Demonstration Area levels:	At Demonstration Area levels:	At Demonstration Area levels:
R2000 Implementation of demonstration projects: - Partnering with NGOs and other implementers. - Capacity building of implementing partners. - Technical assistance to implementing partners. - Formative research. - Impact evaluation. - Dissemination of innovations and results. - Needs-based training. - Strengthening of selected facilities. - Funding selected initiatives.	**R2100** Community-based participatory intervention for rural migrant men	In selected community: - Community needs assessment and baseline evaluation is completed. - Intervention strategies and tools are developed. - Interventions are implemented with community participation. - Outcomes and impacts are evaluated. - Lessons learned and best practices from the initiative are disseminated. - Demonstration project is providing training to other implementers.	- State government supports project activities through funding selected interventions (Risk – medium to high). - Target population is willing to participate in project (Risk – low).
	R2200 Community-based participatory intervention for rural caste-based sex work.	In selected community: - Community needs assessment and baseline evaluation is completed. - Intervention strategies and tools are developed. - Interventions are implemented with community participation. - Outcomes and impacts are evaluated. - Lessons learned and best practices from the initiative are disseminated. - Demonstration project is providing training to other implementers.	- State government supports project activities through funding selected interventions (Risk – medium to high). - Target population is willing to participate in project (Risk – low).
	R2300 A Rajasthan model of the prevention-care continuum is developed and implemented.	In selected sites: - Needs assessment is completed for continuum of care. - Partners are selected, strategies and tools developed. - Care and support programs are implemented; - Outcomes and impacts are evaluated. - Lessons learned and best practices from the initiative are disseminated.	- State government supports project activities through funding selected interventions (Risk – medium to high). - Suitable partners are available (Risk – low).

Logistical Framework Analysis for National Component

Narrative Summary	Expected Results	Performance Measurement	Assumptions/Risk Indicators
Resources	Outputs	Performance Indicators	
At the National level:	At the National level:	At the National level:	At the National level:
N1000 Capacity Building for NACO and selected TRGs: - Technical Assistance - Selected policy research - International linkages	**N1100** Incorporation of international experience and expertise into national HIV/AIDS policy and programming by TRGs and NACO.	- Studies conducted and considered in policy formulation by NACO. - International linkages initiated by project are established.	- NACO and selected TRGs request CEA inputs (Risk – medium) - Policy makers consider HIV/AIDS as a priority public health and developmental issue (Risk – medium).
	N1200 Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming by TRGs and NACO.	- Demonstration project models, experiences and components from Karnataka and Rajasthan are used in other states in India.	

7. KARNATAKA COMPONENT

7.1 SITUATION AND NEEDS ASSESSMENT

7.1.1 Developmental and Socio-demographic Context

The southern state of Karnataka abounds in geographic, demographic and social diversity. It has a total area of 192,000 km^2 and is bordered by the Indian Ocean on the west and by the states of Tamil Nadu, Kerala, Goa, Maharashtra and Andhra Pradesh. Karnataka is now divided into 27 administrative districts including Bangalore, which is divided into urban and rural districts. The population of Karnataka is estimated at approximately 50 million with a population density of 235 per km^2. Approximately 31% of the population is urbanized, with many concentrated in the city of Bangalore, which has an estimated population of approximately five million and is among the fastest growing cities in Asia.

The total fertility rate in Karnataka was 3.87 in 1991, down from 4.70 a decade earlier. The crude birth rate (23 per 1,000) and crude death rate (7.3 per 1,000) are both below the national average. The infant mortality rate declined from 81 to 53 per 1,000 between 1981 and 1997. The infant mortality rate varies substantially by district, ranging from 29 to 75 per 1,000. The life expectancy is 62.1 for males and 63.3 for females. The female to male ratio is 960:1000 and has declined over the past decade.

The overall literacy rate has been increasing from approximately 30% in 1961 to 56% in 1991. However, there are substantial variations across the state, with rural areas having a much lower literacy rate (48%) than urban areas (74%). Females have a much lower literacy level than males (44% vs. 67%). School attendance by children also varies substantially by district. Overall, in 1996 it was estimated that 27.7% of children in Karnataka were out of school but this figure ranged from 12.7% in Urban Bangalore to over 30% in many districts.

There are wide variations in the average annual per capita income in Karnataka, ranging from just over Rs. 6,000 in some districts to over Rs. 15,000 in others. In 1997, approximately 33% of the state's population was below the poverty line compared to 35% nationally. Poverty rates are higher in urban areas (40%) than rural areas (30%). The overall unemployment rate is reported to be around 1%. In 1991, 29% of the workforce was female, compared to 25% in 1981.

The Human Development Index (HDI) is an indicator that summarizes the state of development for a population. It is comprised of measures of a population's longevity (life expectancy), knowledge (literacy rate) and standard of living (per capita income). The Gender-related Development Index (GDI) summarizes the same components but also integrates measures of inequality between men and women in each of the domains. Among Indian states in 1991, Karnataka ranked 7th in HDI (above the national average) and 5th in GDI. This suggests that Karnataka has performed better overall in gender-related development than many other states. However, in all districts of Karnataka, the GDI is lower than the HDI, suggesting that the socio-economic development of women is worse than that for the population as a whole throughout the state.

7.1.2 HIV Situation and Vulnerability

The first persons with AIDS in Karnataka were identified in 1988. Since then, there is evidence that the HIV epidemic has taken hold in the state. Up to October, 1999 there had been 5,616 persons testing positive for HIV in the state and HIV infection has now been detected in every district. There have also been 221 persons diagnosed with AIDS. So far, it appears that the epidemic is more advanced in some districts than in others. The majority of HIV cases reported so far are from the districts of urban Bangalore and Mangalore. Sentinel HIV surveillance has shown that the prevalence of HIV in Bangalore is approximately 10% among STD clinic attenders and is approaching 2% among women attending antenatal clinics. Sentinel surveillance data also suggest that the epidemic is advancing in some rural districts. In some northern districts, HIV prevalence among STD clinic attenders ranges from 20-40% in certain sites and antenatal prevalence in one antenatal clinic in the northern area of Hubli was 1.75% in 1998. The advance of the epidemic is now being reflected in hospitals, as there are reports of a rapid growth in the number of patients being admitted to hospital with HIV-related illness, particularly tuberculosis.

There is little information regarding HIV transmission dynamics in Karnataka. However, data from HIV testing centres have documented very few cases where an identified risk factor was men having sex with men or injection drug use. Although these data are likely influenced by reporting biases, it suggests that much of HIV transmission is heterosexual.

There are a number of factors that contribute to Karnataka's vulnerability to the HIV epidemic. It is bordered by several other states that have well-established and growing HIV epidemics (notably Maharashtra, Tamil Nadu and Andhra Pradesh). Karnataka shares many demographic and economic ties to these neighbouring states. There is extensive migration to and from these states and there are major transportation routes connecting Karnataka to them. This may promote more rapid dissemination of HIV from the epicentres of the epidemic to the population of Karnataka. Karnataka also has an important seaport (Mangalore) on the Indian Ocean. Since this attracts migratory populations and is situated on major national and international trade routes, it will be particularly vulnerable to the introduction and spread of HIV. Karnataka's large and growing urban population will likely promote more rapid spread of HIV as well.

There are also patterns of sexual activity in Karnataka that render it vulnerable to the HIV epidemic. Commercial sex work appears to be prevalent throughout the state. However, unlike some parts of India (such as Mumbai), commercial sex work in many parts of Karnataka is less visible. In the major cities, there are not clearly defined geographic areas where sex work is concentrated. Rather, much of the sex trade is based on the street or in home settings. This pattern of sex work presents enormous challenges for understanding the dimensions of HIV transmission and the delivery of health promotion programs. There are other unique challenges outside of the major urban settings. In some of the northern districts of Karnataka, the prevalence of HIV infection in sentinel sites is as high or higher than in urban Bangalore. Much of this may be related to the presence of important transportation routes. However, it also appears that sex work occurs and may be widespread in some villages and rural areas. In some northern districts, much of this is related to the *devadasi* system wherein there are historical, cultural and religious dimensions to the sex trade.

There are also economic and social factors that contribute to Karnataka's vulnerability. Poverty levels are high (32%, 1987-88 estimate), leading to economic pressures that promote commercial sex work. Furthermore, economic pressures result in migration and social dislocation of labourers (primarily men) who are seeking work. Low levels of literacy, especially among women, retards effective and widespread behaviour change communication. Furthermore, the low social status of women in many settings inhibits the adoption of safer sexual practices.

7.2 INSTITUTIONAL RESOURCES AND RESPONSES

7.2.1 Overview

HIV prevention and control activities in Karnataka are largely under the direction of the Karnataka State AIDS Prevention Society (KSAPS). KSAPS was established in December, 1997, replacing the previous State AIDS Cell. KSAPS has moved rapidly to create efficient administrative structures to distribute funds from the NACP-II. It has also helped to mobilize a variety of NGOs to assist in the implementation of HIV/AIDS prevention, care and support activities. After consultations with KSAPS and other institutional partners, and through a participatory design process with KSAPS, several strengths were identified in the KSAPS response to the HIV epidemic. These are described briefly below.

In Karnataka, there is a relative wealth of highly skilled and committed individuals contributing to HIV prevention, care and support activities. There is also an increasing number of NGOs that wish to contribute to these efforts. In 1998-999, there were 97 NGOs registered with KSAPS; 19 of these were already involved in HIV prevention activities. In addition, Karnataka has many strong medical institutions that are interested in providing technical support to HIV prevention, care and support activities. Many ongoing implementation projects are related to improving general awareness of HIV related issues. There is also an increasing number of NGOs that are engaged in the implementation of preventive interventions, and care and support activities for vulnerable populations. In addition, a network of six NGOs (AIDS Forum Karnataka, AFK) has been created to increase community HIV/AIDS awareness, provide mutual support and coordinate activities in this field.

Ability to mobilize activities

KSAPS has been able to develop relationships with and mobilize institutional partners and NGOs to implement a variety of activities. These activities include:

- The establishment of 8 HIV voluntary testing sites and 14 HIV sentinel surveillance sites throughout the State.
- The creation 10 functional Zonal Blood Testing Centres for the Blood Safety program.
- Initiation of several initiatives for IEC at the population level using a variety of media and approaches.
- Involvement and mobilization of many NGOs in HIV prevention work in Karnataka.
- Implementation of training in HIV-related issues for a variety of health care providers and public health officials.

Ability to manage and distribute funds
KSAPS has developed an effective and efficient administrative structure that has demonstrated a strong capacity to flow funds from NACO through to implementation activities.

Involvement of persons living with HIV/AIDS (PLWHAs)
KSAPS has involved PLWHAs in many of the processes related to the planning and implementation of activities.

7.2.2 Opportunities for Capacity Building

While KSAPS and its implementing partners share many strengths, we identified a number of opportunities for capacity building through our discussions with them. These are summarized below.

Improved availability of information for program planning
Thus far, the only consistently available information about the status of the epidemic is based on HIV sentinel surveillance. Population-based data on the prevalence of STIs and HIV-related knowledge and behaviour are generally not available. It was agreed that enhancement of surveillance systems to provide this type of information would facilitate an improvement in the planning and targeting of HIV programming. In addition to improving the surveillance systems, it was determined that both KSAPS and its implementing partners would benefit from an enhanced capacity to analyze and integrate health information into program planning.

Monitoring and evaluation of programs
Although there are many activities underway, the extent of the quality and impact of many of these activities is uncertain due to a lack of monitoring and evaluation. Improved capacity in this area would allow KSAPS and its implementing partners to modify and improve existing programs and to identify best practices for wider implementation.

High quality training programs for implementers
In some areas, there are already training programs available for implementers. However, there are important areas in which training methods and materials can be improved. These areas include situational analysis and needs assessment, operational research for program formulation and implementation, the design and implementation of HIV prevention programs for vulnerable populations, and the monitoring and evaluation of programs.

STI management systems
Within the public system, STI management is concentrated in clinics at large hospitals. High quality STI management at the "grassroots" level is generally not available through the public system. Most STI management is provided outside of the public system. However, the quality and reach of STI management in the private sector is uncertain. It was agreed that improved systems for STI management at the "grassroots" level is required.

Creation of an enabling environment for HIV programming
While some segments of the population have a high degree of awareness and sensitivity to HIV related issues, this is distributed unevenly. There is still extensive stigmatization of HIV/AIDS

throughout Karnataka society and its institutions. Systems (education and otherwise) for creating awareness in the general population regarding HIV/AIDS can be improved. There is also room to improve the sensitivity and involvement of the medical sector with regard to HIV/AIDS issues. While some medical institutions are well-informed and sensitive to HIV-related issues, this is not uniform. As yet, the private sector (medical and non-medical) has not been fully engaged in HIV prevention efforts.

Gender issues

It was agreed that there is much room for improvement with respect to the status and vulnerabilities of women and the incorporation of gender issues at all levels of planning and implementation.

Integrated models for implementation

While there are many strengths in the systematic response to HIV/AIDS in Karnataka, it was agreed that integration of activities across different sectors and systems could be improved. It was also agreed that there are weaknesses in the linkage between prevention activities and care/support activities at the community level. In particular, there are opportunities for strengthening the cycle of strategic planning, iterative program implementation, and evaluation at the local or district level.

7.3 KARNATAKA COMPONENT PROJECT DESCRIPTION

7.3.1 Overview

As described in Section 4.2 above, throughout the design and implementation of the program in Karnataka, we will pay close attention to the cross-cutting themes that are critical success factors for the prevention of HIV and the mitigation of the impact of HIV/AIDS on the population. These cross-cutting themes are:

- Sustainability and working within KSAPS.
- Integration with overall development.
- Addressing gender issues at every level.
- Creation of an enabling environment and destigmatization.
- Maximal participation of PLWHAs and vulnerable groups in programming.
- Evidence-based grounding of programs.

Based on consultations and the participatory identification of current strengths and opportunities for capacity development, a program plan to improve the capacity in Karnataka to respond to the HIV/AIDS epidemic was developed. There are two main program components:

1) Capacity building of KSAPS and their implementing partners at the state level.

2) Implementation of a high quality demonstration project at the district level.

Capacity building for KSAPS and implementers at the state level (component 1) will be primarily achieved through technical inputs into the planning, implementation and evaluation of HIV prevention and control activities. These technical inputs will include direct consultation

from Canadian and international experts and the provision of high quality training and training materials. Through the implementation of a high quality demonstration project at the district level, we plan to work with NGOs and other implementing partners to plan, implement, evaluate and disseminate effective models and strategies for HIV prevention at local level. Through this mechanism, we intend to build the capacity of implementers, to provide opportunities for applied training, and to provide insights and innovations for replication throughout Karnataka and also in other states.

7.3.2 Work Breakdown Structure

The work breakdown structure (WBS) for activities in Karnataka has two components. The first component (K1000) is "Capacity Building for KSAPS and Implementers, State Level". There are three main outputs for this component with associated activity streams. The second component (K2000) is "Implementation of Area Demonstration Project", which has activities organized under four main outputs. These activity streams are summarized in the figure below. The detailed activities under each of the streams are described in the following sections.

Component K1000 – Capacity Building for KSAPS and Implementers, State Level

- **Output K1100** – Improved KSAPS' and implementers' capacity to gather, analyze and integrate information into decision making.
- **Output K1200** – Enhanced KSAPS' and implementers' capacity to mobilize, monitor and evaluate evidence-based HIV/AIDS programming.
- **Output K1300** – Enhanced KSAPS' and implementers' capacity to create an enabling environment for HIV/AIDS programming.

Component K2000 – Implementation of Area Demonstration Project

- **Output K2100** – Enhanced information base for HIV/AIDS policy, iterative programming, and monitoring and evaluation.
- **Output K2200** – Development of community-based participatory interventions for vulnerable and marginalized men and women.
- **Output K2300** – Increased accessibility to and quality of STI management.
- **Output K2400** – Improved availability of high quality care and support for individuals and families affected by HIV/AIDS.

Component K1000 Capacity Building for KSAPS and Implementers – State Level		
K1100 Improved KSAPS' and implementers' capacity to gather, analyze & integrate information into decision making	**K1200** Enhanced KSAPS' and implementers' capacity to mobilize, monitor & evaluate evidence-based HIV/AIDS programming	**K1300** Enhanced KSAPS' and implementers 'capacity to create an enabling environment for HIV/AIDS programming
K1101 Train KSAPS & implementers in rapid epidemiologic assessment **K1102** Train & assist KSAPS & implementers in collection and analysis of information on STI/HIV, behaviours, and gender & development indicators **K1103** Train and assist KSAPS and implementers in conducting situational analysis and needs assessments **K1104** Train & assist KSAPS in conducting directed research for advocacy and policy formulation **K1105** Train and assist implementers in conducting operational research for program formulation and implementation **K1106** Train and assist KSAPS and implementers in monitoring and evaluating program outcome and impact **K1107** Train KSAPS and implementers in population-based strategic planning of HIV programs	**K1201** Train KSAPS and implementers in best practices in delivery of targeted HIV/AIDS programming **K1202** Train and assist implementers for innovative participatory peer group interventions with vulnerable populations **K1203** Assist KSAPS and implementers in the dissemination and scaling up of effective HIV/AIDS programs **K1204** Train and assist KSAPS and implementers in the development of appropriate voluntary counseling and testing **K1205** Train and assist KSAPS and implementers to establish effective STI management at the "grassroots" level **K1206** Train and assist KSAPS and implementers to integrate prevention, care and support along a continuum	**K1301** Assist KSAPS and implementers to increase the awareness, sensitivity and capacity of public & private sector policy makers and community leaders on HIV/AIDS issues **K1302** Assist KSAPS and implementers to involve PLWHAs and vulnerable groups in all aspects of program design, implementation and evaluation of prevention, care and support programming **K1303** Assist KSAPS and implementers to incorporate HIV/AIDS issues into development, social & gender issues **K1304** Train and assist KSAPS and implementers to develop effective policy and practice for occupational safety of health professionals **K1305** Assist KSAPS and implementers to effectively link prevention to care and support activities **K1306** Develop effective and appropriate training materials and methods

Component K2000 Implementation of Area Demonstration Project			
K2100 Enhanced information base for HIV/AIDS policy, iterative programming, and monitoring and evaluation	**K2200** Development of community-based participatory interventions for vulnerable and marginalized men and women	**K2300** Development of a model for STI management at the "grassroots" level	**K2400** Improved availability of high quality care and support for individuals and families affected by HIV/AIDS
K2101 Select project area and build partnerships with community, NGOs and other partners **K2102** Zone and map project area **K2103** Review and document current information base and develop strategies for information gathering **K2104** Strengthen selected laboratories for HIV/STI diagnostics and surveillance **K2105** Conduct baseline STI/HIV and behavioural surveys and formative assessments **K2106** Analyze and disseminate information to program planners and implementers **K2107** Develop a strategic plan for an integrated model of HIV/AIDS programming in project area **K2108** Develop mechanisms for monitoring activities and impact	**K2201** Identify vulnerable groups and NGOs and other implementers **K2201** Train and mobilize NGOs and other implementers **K2203** Conduct baseline assessments of vulnerable groups **K2204** Train peer educators and supervisors **K2205** Implement interventions using an iterative approach **K2206** Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices **K2207** Provide resources and opportunities for hands on training for other implementers in interventions	**K2301** Conduct a baseline assessment of STI services at the community level **K2302** Select and partner with public and private providers **K2303** Develop and implement training for providers including training in counseling, condom promotion and partner notification **K2304** Develop a strategy for extending STI services to women **K2305** Upgrade selected laboratories to support STI treatment services	**K2401** Review and document current hospital and home-based care practices and resources **K2402** Work with communities and health care providers to identify opportunities and priorities to improve care and support services **K2403** Develop and implement training for care providers **K2404** Strengthen and develop appropriate voluntary counseling and testing services in selected sites **K2405** Support the development of local PLWHA self-help groups **K2406** Train and assist NGOs to develop plans and proposals for community-based HIV care projects

7.3.3 *Description of Outputs and Activities*

Component K1000 – Capacity Building for KSAPS and Implementers – State Level

In this component of the program, a number of strategies will be used to strengthen the capacity of KSAPS and its implementing partners at the state level. These strategies will include:

Technical Assistance/Mentoring: A network of Canadian and international technical specialists will provide direct technical advice, consultation and mentoring for members of KSAPS and implementing agencies. Local Indian technical expertise will also be engaged to offer the same opportunities.

Needs-based Training: Where necessary, direct training for KSAPS members and implementers will be provided, using high quality and validated training materials and methods. This training will involve both short courses and training workshops.

Study Tours and International Linkages: There are many examples of high quality HIV/AIDS prevention, care and support programs both in India and elsewhere. Mechanisms will be developed for linking KSAPS and its implementing partners to these programs, such as through organization and support for study tours, to promote the use of national and international best practices.

Strengthening Facilities and Funding Selected Initiatives: Direct support will be provided for the strengthening of selected facilities that can serve as state-wide resources. For example, this could include the strengthening of a designated facility for the diagnosis of STIs, in support of enhanced STI surveillance and validation of syndromic management guidelines.

Outputs and Activities

The outputs and specific activities under Component K1000 are described below.

Output K1100 – Improved KSAPS' and implementers' capacity to gather, analyze and integrate information into decision making.

Activity K1101 – Train KSAPS and implementers in rapid epidemiologic assessment.

Rapid epidemiologic assessment (REA) includes a set of methods and tools that can be used to quickly assess a population's situation with respect to the prevalence and incidence of HIV infection and other STIs, and the transmission dynamics of HIV/STIs in a community. Thus, improving KSAPS' and implementers' capacity to perform REA can support the formulation of HIV prevention strategies. Training activities will include:

K1101.1 – Prepare and convene training sessions and workshops on REA with designated KSAPS representatives and members of implementing organizations and academic institutions.

K1101.2 – With KSAPS and implementers, develop appropriate tools for REA that can be used in various settings throughout the state.

K1101.3 – Assist KSAPS and implementers to undertake REAs in key population groups or districts where required.

Activity K1102 – Train and assist KSAPS and implementers in the collection and analysis of information on STI/HIV, behaviours, and gender and development indicators.

In addition to REA, organized and ongoing systems for the collection and analysis of population-level information on the prevalence and incidence of STI/HIV, risk behaviours and other parameters are necessary to describe the burden of illness related to STI/HIV, to identify at-risk populations, and to monitor the impact of prevention efforts. Activities to enhance capacity in this area will include:

K1102.1 – Establish a state level Working Group to develop information priorities, review existing information systems, develop a strategic plan for information collection, analysis and dissemination, and develop methods and tools for information gathering and epidemiologic surveillance. The Working Group will be resourced by the Technical Support Unit (TSU) and will include membership from the TSU, KSAPS, NGOs, medical and academic institutions, and the community (including PLWHAs).

K1102.2 – Provide training in quantitative and qualitative methods for the collection, analysis and interpretation of relevant population information through workshops and field experiences.

K1102.3 – Under the guidance of the Working Group, establish pilot systems for information gathering, including surveys and disease surveillance.

Activity K1103 – Train and assist KSAPS and implementers in conducting situation analyses and needs assessments.

To plan and implement effective HIV programming, there must be the capacity to conduct a high quality situation analysis and needs assessments. This process involves analyzing and integrating information regarding the status and drivers of the HIV epidemic in the population, understanding the various intervention options and their rationale, and critically reviewing the available resources and resource gaps. To enhance capacity in this area the following activities will be undertaken.

K1103.1 – Provide training for KSAPS and its implementing partners in the conduct of situation analyses and needs assessments. This training would include the convening of workshops and the development of training materials.

K1103.2 – With KSAPS and its implementing partners, identify priority regions and populations, and formulate plans for and assist in conducting situational analyses and

needs assessments in those areas. These assessments would be used to provide hands-on training opportunities.

Activity K1104 – Train and assist KSAPS in conducting directed research for advocacy and policy development..

Policy decisions are key to creating an enabling environment and ensuring that the most effective interventions are given priority. Evidence from relevant research can be a valuable tool for selecting and advocating policy directions. For example, it can be used to estimate the population impact and cost- effectiveness of various intervention options.

K1104.1 – Together with KSAPS, a set of policy-relevant research questions will be developed and addressed. Technical expertise will be provided to conduct the research and to provide consultation to KSAPS on the process and implications of the findings.

Activity K1105 – Train and assist implementers in conducting operational research for program formulation and iterative implementation.

Operational research is directed at assessing the processes and impacts of programmatic activities. The results of this kind of research are beneficial because they identify ways by which the efficiency and effectiveness of programs can be improved.

K1105.1 – Training in operational research will be delivered through workshops and hands-on training experiences.

K1105.2 – With KSAPS and implementers, an agenda for operational research will be developed that focuses on important intervention activities in the state. Subsequently, operational research projects will be jointly developed and the results integrated into program formulation and implementation.

Activity K1106 – Train and assist KSAPS and implementers in monitoring and evaluating program outcomes and impacts.

Program monitoring and evaluation is necessary to ensure that programmatic activities are using efficient processes and achieving desired results.

K1106.1 – Direct training will be provided for KSAPS and implementers in the conduct of program monitoring and evaluation through workshops and hands-on training.

K1106.2 – With KSAPS and its implementing partners, systems for monitoring and evaluating key state level programs will be developed.

Activity K1107 – Train KSAPS and implementers in population-based strategic planning of HIV programs.

To maximize the impact and cost-effectiveness of HIV/AIDS program activities, planning should be strategic, evidence-based and appropriate to the local population situation. The following activities will be undertaken to enhance capacity in this area.

K1107.1 – Provide direct training for KSAPS and implementers in strategic planning.

K1107.2 – Convene strategic planning workshops that involve KSAPS, implementers, community participants and other key stakeholders.

Output K1200 – Enhanced KSAPS' and implementers' capacity to mobilize, monitor and evaluate evidence-based HIV/AIDS programming.

Activity K1201 – Train KSAPS and implementers in best practices in delivery of targeted HIV/AIDS programming.

There are many examples of excellent programs that are delivering targeted HIV/AIDS interventions in India and elsewhere that could be described as representing best practice in the field. The capacity of KSAPS and implementers to deliver targeted interventions will be strengthened by increasing their knowledge of these high quality programs.

K1201.1 – Review and summarize examples of best practices in India and elsewhere and translate this information to KSAPS and implementers through structured meetings and workshops. This process will include reviewing and disseminating best practice documentation from national Technical Resource Groups.

K1201.2 – Arrange for interaction between KSAPS and implementing partners and best practice programs by convening joint meetings and supporting study tours.

Activity K1202 – Train and assist implementers for innovative participatory peer group interventions with vulnerable populations.

K1202.1 - Provide technical training to KSAPS, NGOs and other implementers in executing peer education programs. This would include training on the rationale for targeted interventions, the methodology for selecting target sites and zones and for recruiting peer educators, and the importance of focus and intensity. It would also include how to conduct baseline surveys and formative assessments, how to develop and use participatory methods and materials, how to train peer educators to train their peers and how to monitor program outputs for the duration of the program. Such training expertise can be sourced within India or internationally.

K1202.2 - Provide technical assistance to NGOs implementing peer group interventions. Follow-up technical support would be provided to the NGOs who receive the initial training. Such technical support would include the provision of support in carrying out

comprehensive mapping and zoning exercises, designing formative and baseline assessment tools, recruiting and training peer educators, and in developing a range of participatory educational materials. Support would also be provided to NGOs in developing and designing monitoring and evaluation indicators and related data collection tools.

K1202.3 – Initially, the project, in partnership with KSAPS, implementers and target groups, will jointly develop processes and indicators of empowerment for vulnerable target populations. In the interests of sustainability and community ownership, work with vulnerable populations will try to emulate the lessons learned by the Sonagachi project and similar high quality projects in India. Some such projects are now largely run by the sex workers themselves and has extended the range of issues addressed to include such social issues as legal reform, literacy and affirming sexuality. An exchange visit involving KSAPS, implementers and sex workers will help inform this process.

Activity K1203 – Assist KSAPS and implementers in the dissemination and scaling up of effective HIV/AIDS programs.

As effective programs are developed by implementers in specific populations, an important challenge is to disseminate the knowledge and scale up capacity across the state.

K1203.1 – Working with KSAPS and implementing partners, effective programs will be reviewed and documented. This information will then be shared with implementers in other parts of the state through written documentation, and presentations at meetings and conferences.

K1203.2 – Workshops or symposiums will be convened to promote interaction and the sharing of experiences between implementers that are already engaged in effective programming and those that are at an earlier stage of implementation.

Activity K1204 – Train and assist KSAPS and implementers in the development of appropriate voluntary counseling and testing services.

K1204.1 - Conduct initial VCT training for KSAPS and implementers.

K1204.2 - In partnership with KSAPS and implementers, conduct a review of VCT services in the public and private sectors in Karnataka State. Identify strengths and weaknesses and develop an agreement within KSAPS and health institutions regarding the steps required to improve existing VCT services.

K1204.3 - Following the review of VCT services, develop an agreement with KSAPS and partners regarding the expansion of cost-effective, quality VCT services in Karnataka.

K1204.4 - Provide pre and post-test HIV counseling training for KSAPS and relevant staff in key health institutions providing VCT. Such training would include a review of

the legal framework in India for HIV testing, the key components of pre and post-test counseling, the vital importance of informed consent and confidentiality (individual or shared) regarding test results, and follow-up counseling support and referral for HIV positive clients.

K1204.5 - Provide feedback to the HIV/AIDS forum (cf. K1301.1) regarding findings, conclusions and recommendations on VCT in Karnataka State.

Activity K1205 – Train and assist KSAPS and implementers to establish effective STI management at the "grassroots" level.

K1205.1 - Conduct initial STI syndromic management training for KSAPS and relevant partners.

K1205.2 - In collaboration with KSAPS and its key partner health institutions, conduct a review of STI management in Karnataka. Assess the extent to which STI treatment is laboratory dependent or syndromic, stigmatized or freely used by men and women. Provide feedback to the KSAPS Management Committee on key findings. Develop an agreement within KSAPS and the health sector regarding the institutions to which STI management should be initially devolved (for example, primary health care centers, district hospitals, family planning services, and/or gynecologists).

K1205.3 – Provide information for KSAPS and partners regarding the required technical supports for STI management such as simple algorithm flow-charts, drug lists for syndromic management of STI and a drug record card, partner referral cards, penile models and condoms, an examination couch and a separate room for carrying out the physical exam and counseling. Provide technical support to KSAPS and the health sector in developing the foregoing supports, and well as relevant back-up laboratory services.

K1205.4 - Train the trainers from targeted health institutions to provide the following training: syndromic management, supervision of syndromic management and counseling skills.

K1205.5 - Assist health facilities to set up an STI treatment reporting system within the health sector with information transfer to KSAPS.

K1205.6 - Assist KSAPS in carrying out training of health providers. Provide ongoing technical support in the implementation of all the foregoing.

Activity K1206 – Train and assist KSAPS and implementers to integrate prevention, care and support along a continuum.

A key challenge in HIV/AIDS programming is the integration of a wide range of activities from prevention to care and support. This type of integration is beneficial since the various activities are mutually supportive and the complementary strengths of various implementers

can be promoted. Training of KSAPS and implementers in this activity will rely on lessons learned through the district level demonstration project.

K1206.1 – Integrated activities in the demonstration project will be documented and communicated to KSAPS and implementing partners.

K1206.2 – Visits to the demonstration project to review the integrated model will be arranged for KSAPS and implementers.

Output K1300 – Enhanced KSAPS and implementers' capacity to create an enabling environment for HIV/AIDS programming.

Activity K1301 – Assist KSAPS and implementers to increase the awareness, sensitivity and capacity of public and private sector policy makers and community leaders on HIV/AIDS issues.

K1301.1 - Set up a state level HIV/AIDS forum for policy makers. This forum would be made up of senior government, public and private health sector, research and NGO personnel. The purpose of this forum would be to review and discuss HIV policy and program issues with a focus on inter-sectoral linkages, and to educate policy makers regarding HIV/AIDS issues. This forum would be convened a minimum of twice yearly by KSAPS and would set priorities for its work, review up-to-date research and information within priority programming areas and advise on problem areas as they arise. The forum would be convened by KSAPS. Preparing materials for the forum's consideration and input would be the joint responsibility of KSAPS and the project. To the fullest extent possible the forum will be made up of both men and women and have representation from women's organizations. Policy makers from the demonstration site area would also participate in this forum.

K1301.2 - An information newsletter/bulletin will be produced by the project at least twice a year. This newsletter/bulletin will cover areas of relevance to HIV/AIDS policy and program frameworks for HIV/AIDS prevention and care. It will be produced in English, Kannada and Hindi. Gender issues will be integrated. This newsletter could be produced jointly with the Rajasthan office.

K1301.3 - Sensitize community leaders to HIV/AIDS issues. In order to work at the community level, it is vital to have the support of local community leaders. Ignored or poorly educated community leaders can sabotage an initiative's best efforts if their understanding and support has not been solicited in advance. The project will provide technical assistance to KSAPS and NGOs in understanding the importance of sensitizing community leaders, in how to identify relevant community leaders for sensitization, and in the provision of educational materials/talks to such leaders. One appropriate mechanism for providing technical support to the NGOs is through the KSAPS' NGO network.

Activity K1302 – Assist KSAPS and implementers to involve PLWHAs and vulnerable groups in all aspects of program design, implementation and evaluation of prevention, care and support programming.

The involvement of PLWHAs and vulnerable groups in the design and implementation of HIV/AIDS programming helps to ensure that programming is appropriate, effective and sensitive to the needs of those most affected by the programs.

K1302.1 – The Project will include PLWHAs and affected vulnerable groups in all aspects of the design and implementation of its program activities, thus providing a model for other implementing agencies.

K1302.2 – Meetings and workshops will be convened to engage PLWHAs and vulnerable populations in focused discussions regarding programmatic needs and policy issues related to HIV/AIDS.

Activity K1303 – Assist KSAPS and implementers to incorporate HIV/AIDS issues into development, social and gender issues.

K1303.1 - This component is designed to work with organizations not directly involved with KSAPS or the Project. Therefore, the first task will be to map the range and type of organizations that exist. The second task will be to understand how people are currently being educated about HIV/AIDS transmission and how their current HIV-related care and support needs are being met. The third task will be to identify organizations with potential and interest in collaborating with KSAPS and the project. Ranges of social change, development and gender initiatives exist in both rural and urban Karnataka. The project will encourage KSAPS' implementers to work with a selected number of these initiatives. This is in order to promote HIV/AIDS education and prevention within these organizations and to link to service organizations providing a continuum of care for those who are sick, dying or orphaned. This can be accomplished in a number of ways.

K1303.2 - One strategy for integrating HIV/AIDS issues into social change, development and gender initiatives is through strengthening the existing KSAPS NGO network and bringing members together with a view to sharing information with each other. This information could include identifying which organizations have potential for networking. The KSAPS NGO network could then develop strategies for expanding their HIV prevention efforts through such organizations and at the same time carry out advocacy and HIV information provision among service providers relevant for HIV-related prevention, care and advocacy.

K1303.3 - Another strategy for integrating HIV/AIDS issues into social change, development and gender initiatives is to encourage KSAPS' NGO implementers to participate in other NGO coalitions and advocacy groups addressing development, social change and gender issues, e.g. FEVORD (rural development NGO network). The idea would be to provide a voice for HIV/AIDS issues and to advocate for the inclusion of HIV issues in information and advocacy agendas, for example, human rights organizations and reproductive health organizations. In addition, HIV/AIDS

implementers' participation in other coalitions could provide an advocacy forum to encourage service providers not to turn away PLWHAs.

K1303.4 - Another strategy would be to encourage NGOs implementing HIV prevention and care programs to liaise directly with certain groups on a one-to-one basis.

K1303.5 - To support the above activities the project would help the NGO network to develop relevant information and advocacy materials. These could include simple one-page fact sheets on a range of HIV-related issues in order to support their advocacy and information sharing agenda. Such fact sheets could include for example, The urgency of preventing HIV in India, how a person can and cannot get infected with HIV, HIV as a reproductive health issue, the care and support needs of PLWHAs, myths concerning HIV. It is anticipated that this component will start up sometime after the second year of the project.

Activity K1304 – Train and assist KSAPS and implementers to develop effective policy and practice for occupational safety of health professionals.

K1304.1 - The convening of an expert committee drawn from the Indian health sector (public and private) can best effect the development of an occupational safety policy on HIV for health professionals. In addition, project staff and KSAPS representatives would also participate on this committee. Such a committee should include both doctors and nurses. This committee could make its initial recommendations to the policy forum and the KSAPS Management Committee.

K1304.2 - Any policy developed should be context-specific and realistic, and address the real and perceived risks of health workers. Such a policy should keep in mind the cost of universal precautions versus discrete use of such precautions – gloves, for example – and the likely stigmatization of PLWHAs arising from such use. Such a policy should also address the very real risk of tuberculosis infection and the precautions necessary for its prevention among health workers. Given that blood and body fluid exposure during the delivery of newborns is one area of grave concern to heath workers, specific attention should be given to this issue.

K1304.3 - In order to promote the occupational safety of health professionals, they first need to thoroughly understand how they are and are not at risk. Then they need to be guided by their health facility's policy on occupational safety and HIV, and be supervised in ensuring that adequate, but non-discriminatory precautions are taken. Some training on occupational safety and HIV for health workers and their supervisors will be required. Therefore, the project will assist KSAPS in the development of training materials on occupational safety and HIV.

Activity K1305 – Assist KSAPS and implementers to effectively link prevention to care and support activities.

K1305.1 - Emerging best practices from around the world indicate that at the level of vulnerable communities at least, sustainable success is associated with integrated

programming. Two examples are the link between HIV testing and PLWHA support groups, and care and support for peer educators who have worked to promote safer sex practices who become sick and/or leave orphaned children behind when they die. Building an environment where people feel safe to be tested for HIV requires more than clean needles and test kits. It requires some change in legal frameworks, employment laws, counseling support and the support of others living with HIV. Building sustainable community responses to HIV prevention and care requires a strong link between the two from the outset. The more cared for a person with HIV feels, the better chance she or he will care about infecting others.

K1305.2 - The project will encourage KSAPS to make strong policy and program links between prevention and care. This will be done initially by providing input to the policy forum and the KSAPS Management Committee. This input will be based on two elements, a literature review of experiences from other countries and from within India, and working with KSAPS' implementing partners to document their experiences to date in the link between prevention and care. Finally, the demonstration project experience will actively link prevention and care programming, and these experiences and lessons learned will be available to KSAPS by the fourth and fifth years of the Project.

Activity K1306 – Develop effective and appropriate training materials and methods.

K1306.1 - The Project Office will constitute a technical resource to KSAPS and implementing partners. The project will hire a training materials development expert, and where necessary help produce a range of training manuals and materials for program implementers. One of the first tasks for the project will be to identify the training to be carried out within each program area and the support materials needed for this training. Possible training courses/materials include, Syndromic Management of STI, STI/HIV Counseling Skills for Health Workers, STI/HIV Supervision Skills for Health Workers, Home-based Care for People with HIV/AIDS, Mobilizing and Training Vulnerable Groups, and HIV and Gender. Training materials could also include materials and methods developed for peer educators with low literacy skills working in low literacy environments. Many of the above training manuals have already been developed in India or elsewhere. Such manuals may be adapted in a culturally and linguistically appropriate way. Negative gender stereotypes will not be reinforced in any of these training materials. Technical assistance can be provided from within and without India.

Component K2000 – Implementation of Area Demonstration Project.

In this component, a comprehensive demonstration project within a district in Karnataka will be developed and implemented. An integrated implementation program will be established that will not only improve the HIV/AIDS situation within the selected district but will also serve as a model whose processes, methodologies and materials can be replicated in other districts across the state and in other states. Selection of the district for implementation will be based upon discussions with KSAPS. The criteria that will be used in the selection process include vulnerability to HIV/AIDS, size of the district, availability of basic infrastructure, and motivation and interest of the district.

There are several reasons for using this approach. First, there are currently few examples of high quality, integrated models for HIV/AIDS prevention, care and support in India or elsewhere. Second, by focusing at the district level it will be possible to gain and share insights into the processes, costs and impacts of various program activities at the organizational level, where many HIV/AIDS prevention and control efforts will ultimately be delivered. Third, although there are currently many activities and resources being directed to major urban areas such as Bangalore, there are fewer resources being applied in non-urban districts. Fourth, such an approach could provide a single venue for the provision of high quality, hands-on training for implementers from across the state and the country. Finally, this approach will allow for concentration of resources in a way that maximizes the ability to build capacity through the transfer of skills and knowledge. The main strategies will be used in implementing the demonstration project are listed below.

Partnering with NGOs and other implementers: Partnerships with key NGOs and other implementers will be identified and developed within the district.

Capacity building of implementing partners: The capacity of implementing partners will be built through training and other initiatives.

Technical assistance to implementing partners: In addition to training, a network of technical resources using both Canadian, international and Indian expertise will be made available to implementing partners.

Formative research: Formative research will be conducted with implementing partners to guide the development of implementation activities.

Rigorous outcome evaluation: Mechanisms to rigorously document the outcome of interventions will be developed. This will be used as part of an iterative process to understand, modify and improve interventions.

Dissemination of innovations and results: Innovations, results and lessons learned in the demonstration project will be actively disseminated. The goal will be to replicate effective programmatic components across the state and elsewhere in India.

Outputs and Activities

Output K2100 – Enhanced information base for HIV/AIDS programming and monitoring and evaluation.

A central principle guiding the development of the demonstration project is that program planning will be strategic and based on a strong foundation of population level information regarding the epidemiologic, social and cultural aspects of HIV/AIDS in the district. Therefore, the initial set of activities will focus on assessing and improving the information base within the district.

Activity K2101 – Select project area and build partnerships with community, NGOs and other partners.

K2101.1 – The first activity will be to work with KSAPS to select the project area district based on the criteria described above.

K2101.2 – Once the project area is selected, the next step will be to develop partnerships with communities and implementers within the district. With implementing NGOs, group and one-on-one information sessions with relevant community leaders will be convened. Such sessions can be held with a range of representatives – governmental, business, community representatives, or representatives from target populations. Such information sessions are a prerequisite for any entry into a community.

K2101.3 – A district level project team will be established. This team will include membership from the Technical Support Unit, KSAPS, the District Medical Officer, key NGOs and institutions, and community representatives including PLWHAs and members of vulnerable populations. The mandate of the project team will be to develop a strategic plan for project activities, establish working groups to plan and execute programs, help to coordinate activities in the state, develop and review proposed activities, review the progress of the program and participate in the dissemination of innovations to other jurisdictions.

Activity K2102 – Zone and map the project area.

Before developing an information strategy, the project area will need to be zoned and mapped.

K2102.1 - In partnership with NGOs and other implementers procure maps of the project area and conduct more detailed mapping of key geographic areas within it.

K2102.2 - Carry out zoning of the project area with an emphasis on key geographic sites within the district.

K2102.3 - Produce a number of copies of final, zoned maps - one for the project district office, one for each implementing NGO and one for the Karnataka project office.

Activity K2103 – Review and document current information base and develop strategies for information gathering.

2103.1 – Establish an information technical working group to develop strategies for information gathering.

2103.2 – Work with district level health system personnel, medical institutions, NGOs and other agencies to identify current relevant information available in the district and to document information gaps.

2103.3 – Based on the review, the working group will develop a comprehensive strategy and specific plans for enhancing the information base.

Activity K2104 – Strengthen selected laboratories for HIV/STI diagnostics and surveillance.

K2104.1 – Through the working group, determine the requirements for HIV/STI laboratory support in the district and specify capacity strengthening needs.

K2104.2 – Identify and partner with selected laboratories.

K2104.3 – Engage technical experts in HIV/STI laboratory methods to develop specific plans for capacity strengthening at the selected laboratories.

K2104.4 – Implement laboratory strengthening activities.

Activity K2105 – Conduct baseline STI/HIV and behavioural surveys and formative assessments.

Before embarking on planning programmatic activities, a baseline assessment of the current STI/HIV transmission dynamics is required. This baseline assessment is also necessary to monitor progress. In addition to collecting epidemiologic data, an assessment of the social, cultural and institutional context is required.

K2105.1 – Conduct a rapid ethnographic assessment and qualitative investigation of the social and cultural context to guide the development of survey methods and instruments.

K2105.2 – Plan and conduct population-based surveys of the prevalence of STIs and HIV in high risk and general population samples.

K2105.3 – Plan and conduct surveys regarding knowledge, attitudes and practices in high risk and general populations.

K2105.4 – Conduct a formal assessment of the social, cultural and institutional context.

Activity K2106 – Analyze and disseminate information to program planners and implementers.

Once the baseline assessments are completed, the information will need to be disseminated to program planners and implementers to assist in a strategic planning.

K2106.1 – Prepare and disseminate reports based on the baseline assessment.

K2106.2 – Convene meetings to present the results of the baseline assessment.

Activity K2107 – Develop a strategic plan for an integrated model of HIV/AIDS programming in the project area.

The next step will be to use the information from the situational assessment to develop a strategic plan for an integrated model of HIV/AIDS programming.

K2107.1 – Conduct workshops with the district project team to review the findings and implications of the situational assessment.

K2107.2 – Assist the district project team to develop a strategic plan for programming in the project area that includes an identification of priority populations and interventions.

K2107.3 – Develop a specific workplan with the district project team.

Activity K2108 – Develop mechanisms for monitoring activities and impacts.

Once the strategies and workplans are developed, mechanisms to monitor the impact of activities will be created.

K2108.1 – Work with the district project tam to develop a model for project monitoring and evaluation.

K2108.2 – Develop a workplan for monitoring activities.

Output K2200 – Development of community-based participatory interventions for vulnerable and marginalized men and women.

Activity K2201 – Identify vulnerable groups, and NGOs and other implementers.

K2201.1 - In partnership with KSAPS, conduct an assessment of the demonstration project area. Make initial identification of vulnerable groups (migrant male workers, truckers, sex workers, *devadasi*, etc.). Choose which groups to work with.

K2201.2 - Identify and assess relevant NGOs working in the area. Select NGO implementers.

Activity K2202 – Train and mobilize NGOs and other implementers.

K2202.1 - Provide training for NGOs and other implementing partners in the basic facts about HIV transmission, the epidemiology of HIV, and the rationale for targeted interventions. NGO training would also include the following: how to map and zone target areas, how to mobilize vulnerable groups, how to select and train peer leaders, how to support peer leaders in their ongoing work of promoting partner number reduction, condom use, STI, care and support referral, and finally, how to monitor and evaluate their work.

Activity K2203 – Conduct baseline assessments of vulnerable groups.

K2203.1 - Design survey tool for each target group. Ensure that questions regarding attitudes to men and women and sexuality are included as well as basic questions concerning sexual behavior and knowledge about STI/HIV transmission and prevention.

K2203.2 - NGOs/implementers to pre-test survey tools.

K2203.3 - NGOs to carry out surveys of each target community.

K2203.4 - Project/NGOs/implementers to enter and analyze data.

Activity K2204 – Train peer educators and supervisors.

K2204.1 - With NGOs and other implementers, agree on criteria for peer educators.

K2204.2 - NGOs and vulnerable communities to select peer educators. Each peer educator to be responsible for 50 peers.

K2204.3 - Conduct training of peer educators. Provide training materials to NGOs/implementers. Provide selected training support to NGOs/implementers.

K2204.4 - Agree, what (if any) remuneration will be provided to the peer educators.

K2204.5 - Equip peer educators with participatory education materials, group registers, and checklists to register attendance, topics discussed, number of condoms distributed, number of STI referrals and other areas of concern to the group.

K2204.6 - Ensure that NGOs/implementers collect and compile peer leader data on a monthly basis.

Activity K2205 – Implement interventions using an iterative approach.

K2205.1 – Mentor NGO staff and peer educators' collaboration in health promotion activities and empowerment activities among target groups.

K2205.2 – Assist NGO staff and peer educators in establishing and maintaining effective peer group structure, dynamics and organization by ensuring that appropriate monitoring and supervisory tools are in place, and adequate supplies (of condoms and other materials) are available. Encourage groups to organize around issues of common concern whether directly HIV-related or not. Peer leaders may be issued with T-shirts and bags and receive a small monthly stipend.

K2205.3 - Assist NGO staff in supporting peer educators in their functions by advising on the development of specific educational approaches (one-minute sketches, role-plays).

K2205.4 – Train NGO staff to respond to emerging needs and problems of the peer educators or their groups and resolve conflicts.

K2205.5 – Plan, conduct and analyze surveys of the impact of the demonstration project on sexual attitudes and behaviour and other indicators in target groups.

Activity K2206 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices.

K2206.1 – Create documentation of all aspects of the intervention, including procedure manuals, survey instruments and training materials.

K2206.2 – Conduct periodic systematic reviews of the processes and outcomes of the intervention project.

K2206.3 – Analyze and synthesize the processes and impacts and identify the critical success factors for the project. Provide written documentation of this analysis for KSAPS, implementers and national groups such as relevant technical resource groups.

Activity K2207 – Provide resources and opportunities for hands-on training for other implementers in interventions.

It is anticipated that the intervention project will provide opportunities for training of implementers in the design and implementation of high-quality interventions.

K2207.1 – Develop training manuals and materials based on the demonstration project activities.

K2207.2 – Train leaders in the demonstration project to provide hands-on training for personnel from various implementing agencies.

K2207.3 – Provide hands-on training programs within the demonstration project.

Output K2300 – Development of a model for STI management at the "grassroots" level.

The management of STIs plays a central role in HIV prevention. Effective STI management programs provide effective treatment and counseling services through accessible and acceptable delivery models. However, in India there are few models for STI management at the local level.

Activity K2301 – Conduct a baseline assessment of STI services at the community level.

The first step will be to assess the current patterns of delivery and practice of STI management within the project area.

K2301.1 – Through interviewing key informants from the community and public and private health care systems, identify current patterns of STI service delivery.

K2301.2 – Conduct a review of current practices by surveying community members, STI clients and providers.

Activity K2302 – Select and partner with public and private sector providers.

K2302.1 – Public and private health sector care providers will be identified for partnership in the development of a model for STI management at the "grassroots" level. This process will likely involve identifying a geographically-bounded area for implementation.

Activity K2303 – Develop and implement training for providers, including training in counseling, condom promotion and partner notification.

Once a cadre of providers have been identified, they will be provided with training for optimal care delivery.

K2303.1 – An initial workshop will be convened to assess training needs.

K2303.2 – Training materials will be developed and tested.

K2303.3 – Training in syndromic management and counseling, condom promotion and partner notification will be provided.

Activity K2304 – Develop a strategy for extending STI services to women.

A key component of the STI model will be establishing mechanisms to extend STI services to women.

K2304.1 – Conduct a review of the current patterns of STI care delivery to women.

K2304.2 – Assess the accessibility and acceptability of services through surveying women.

K2304.3 – Review opportunities to extend services to women through public and private providers and through reproductive health care systems.

K2304.4 – Develop a training and implementation strategy for extending STI services for women.

Activity K2305 – Upgrade selected laboratories to support STI treatment services.

Much of this activity is described under Activity 2104. The focus for this activity is on providing diagnostic support to providers.

K2305.1 – Once a group of providers has been selected for the STI model, identify and partner with an appropriate and accessible laboratory.

K2305.2 – Develop a protocol for screening and testing samples for STIs that is appropriate for the support of a syndromic management model. The focus will be on validating treatment algorithms including an assessment of the prevalence and antibiotic resistance patterns of etiologic agents.

K2305.3 – Develop a system for obtaining and processing clinical specimens through the laboratory.

Output K2400 – Improved availability of high quality care and support for individuals and families affected by HIV/AIDS.

An important component of any HIV control program is the availability of high quality care and support for individuals and families affected by HIV/AIDS. Therefore an important part of the demonstration project will be to enhance the quality of care and support in the project area. The following activities will be conducted.

Activity K2401 – Review and document current hospital and home-based care practices and resources.

K2401.1 – Within the project area conduct a systematic review of the current hospital and home-based care practices and resources.

K2401.2 – Document the findings of the review and share it with care providers and institutions to validate the findings.

Activity K2402 – Work with communities and health care providers to identify opportunities and priorities to improve care and support services.

K2402.1 – Once the review has been completed, institute a process to identify opportunities and priorities for improved care and support. This process will include workshops and will ensure the participation of health care providers from the institutional and community sector as well as affected populations, especially PLWHAs.

Activity K2403 – Develop and implement training for care providers.

Care providers may not have the appropriate training or resources to improve care and support in institutions or in the community. Therefore, training for care providers will be provided.

K2403.1 – Conduct a survey of community and institution-based health care providers, assess their current knowledge of care issues and determine training needs.

K2403.2 – Develop a training program for care providers that is responsive to their training needs.

K2403.3 – Develop or adapt training materials for care providers.

K2403.4 – Implement training programs with an emphasis on practical training approaches.

Activity K2404 – Strengthen and develop appropriate voluntary counseling and testing services in selected sites.

An important component of care and support is the availability of appropriate voluntary counseling and testing (VCT) for HIV.

K2404.1 – Review the availability and processes of VCT in the project area.

K2404.2 – Provide training for providers in VCT with an emphasis on the principles of confidentiality and in counseling techniques.

Activity K2405 – Support the development of local PLWHA self-help groups.

K2405.1 – Identify any local PLWHA groups.

K2405.2 – Support collaboration and linkages between any existing local PLWHA groups and state and national groups.

K2405.3 – If no groups exist, work through community groups and with state-level and national PLWHA groups to encourage the development of local groups.

K2405.4 – Involve local PLWHA groups in all aspects of project design and particularly in the development of care and support services.

Activity K2406 – Train and assist NGOs to develop plans and proposals for community-based HIV care projects.

The current process for the funding of new community-based HIV care projects is centralized with NACO. Based on working with local communities in the project area, we will encourage and support the development of plans and proposals for innovative community-based HIV care projects.

K2406.1 – With the local community conduct and document a situation analysis and needs assessment for community-based care.

K2406.2 – Work with community-based and institutional care providers to develop proposals for new community-based care projects.

8. RAJASTHAN COMPONENT

8.1 SITUATION AND NEEDS ASSESSMENT

8.1.1 Developmental and Socio-demographic Context

Covering an area of 342,000 sq. km. representing 10.4% of India's land mass, Rajasthan is the second largest state in India and supports a population of about 50 million. Situated in the northwest of the country, it shares an international boundary and the Thar Desert with Pakistan and state boundaries with Punjab, Haryana, Uttar Pradesh, Madhya Pradesh and Gujarat. National highways cross 60% of Rajasthan's 32 districts, with the busiest being the Delhi-Jaipur-Mumbai Highway Number 8, with an estimated 25,000 vehicles passing daily. With slowing growth, an admitted fiscal crisis, increasing groundwater depletion and environmental degradation combined with shortages of electrical power, the indicators of social development in Rajasthan are poorer than many Indian states. In 1997, the infant mortality rate was 85 per 1000 live births (All India 71), the overall literacy for the population aged 7 years and above was 55% (All India 62%), and the female literacy rate was 35% (All India 50%). The total fertility is 4.4 children (versus 3.1 for All India) and child malnutrition measured by height for weight is 41.6%. About 12% of the population is tribal, inhabiting mainly the hilly, rugged southeast region.

Gender disparities are evident in Rajasthan's skewed sex ratio of 913 females for 1000 males. The female literacy rate remains less than half the male literacy rate and is particularly low among disadvantaged social and ethnic groups. Only 17% of 6-14 year old girls from the poorest 40% of households in Rajasthan are in school and 2% of 15-19 year old girls from the poorest households have completed 8 years of primary school.

The Government of Rajasthan (GOR) is expending moderately high levels of state finances on health (6.3% of government expenditure and 1.3% of gross state domestic product), but the vast size of Rajasthan and its desert and tribal regions pose challenges to the delivery of accessible good quality health care. Allocation of resources in the health sector is heavily weighted in favour of tertiary care services. Salary costs absorb most of the resources, leaving operations and maintenance chronically under-funded. Among the innovations in health care delivery are the variety and reach of various peripheral health workers. There are more than 16,000 female health workers (FHWs) and male multipurpose workers (MPWs). Within a UNICEF sponsored program, over 27,000 health workers are providing health care services through the Integrated Child Development Scheme (ICDS).

Private sector participation in health care delivery is relatively low throughout Rajasthan. Composed of a heterogeneous group of unqualified practitioners (also known as "quacks"), practitioners of traditional medicine, and not-for-profit and for-profit allopathic providers, the private sector appears to be weakly organized, has little or no contact with the pubic sector, and has little accountability to the public. There are few standards for quality of health care, pricing, or patient protection. To date, public-private partnerships have not been well explored in Rajasthan and as a result, work to improve the quality, performance, scope, and involvement in

the prevention and promotion aspects of HIV/STD care in both the public and private sectors will break new ground.

8.1.2 HIV Situation and Vulnerability

The first case of AIDS in Rajasthan was detected in 1987 at Pushkar (Ajmer) and as of August 1999, 108 AIDS cases (exposure category: heterosexual activity 78.7%, blood transfusion 4.6%, unknown 16.7%) and 2,229 HIV-positive persons had been reported to the Rajasthan State AIDS Control Society (RSACS). A state HIV surveillance centre was established in 1987 at the Microbiology Department of SMS Medical College, Jaipur. Sentinel HIV surveillance is conducted in 3 antenatal (ANC) clinics (Jaipur, Kota and Jodhpur) and 2 STD clinics (Jaipur and Udaipur). In 1998, 0/1200 ANC samples and 14/300 (4.7%) STD samples were positive. In 1999, 3/1,200 (0.25%) ANC samples and 16/500 (3.2%) STD samples were positive. In 1998 for Rajasthan as a whole, 21/3,019 (0.69%) of female blood donors and 388/109,310 (0.35%) of male donors were HIV-positive.

In 1998, estimates of the number of people living with HIV in the state ranged from 107,000 to 167,000. STD surveillance figures for January to August 1999 indicate 4,285 new STD cases (38.6% men and 61.4% women). Of 438 genital ulcers reported, *herpes genitalis* accounted for 46.1%, chancroid for 25.3%, and syphilis for 20.8%. In the first Rajasthan Family Health Awareness Week, which attracted 27.9% of the 1.9 million population for which it was designed, 8,337 STD diagnoses were made and treatment provided at primary health care centres.

Tuberculosis was the most common diagnosis among AIDS cases (59%). A study in 1997 found low levels of knowledge about STI and HIV in sex workers (9% and 18%), truck operators (28% and 37%), injection drug users (5% and 8%), rural inhabitants (14% and 34%) and urban inhabitants (18% and 59%). Having suffered from an STI in the previous 12 months was reported by 74% of truck operators, 42% of sex workers, 21% of intravenous drug users (IDU), 44% of rural and 36% of urban inhabitants. Low levels of knowledge about STI and HIV and the high prevalence of STI in Rajasthan indicate high vulnerability for HIV transmission in the state.

Additional factors contributing to Rajasthan's vulnerability to HIV are labour migration, both inward migration from surrounding states and Bihar, as well as outward migration, particularly to high HIV prevalence urban centres such as Mumbai. Male mobility is associated with sex work, particularly along the national highway corridors and in specific areas of the major cities, although in urban settings sex work appears diffusely located. Scattered throughout the state are Scheduled Caste communities whose entire economy is dependent on sex work by their women. Among these castes are the *Nats* and the *Rajnats*, both of which were traditionally entertainer castes. These communities now live in sex work villages, dotted along the major highways and near other centres of commercial activity. The communities are networked to one another and women move between villages. Women from these communities may also migrate to large urban centers or neighbouring countries, remitting their earnings to their families. These communities are so economically tied to sex work by their women that females are highly valued by their families. The birth of a girl child is welcomed and the female male sex ratio is closer to normal in these communities. The villages may be relatively affluent compared to surrounding villages but they are extremely marginalized and stigmatized, which poses challenges to HIV

prevention activities. NGO and other development partners reported open hostility and threats of violence toward anyone other than customers approaching these villages. However, these communities are very important in HIV prevention in Rajasthan as they are a major source of commercial sex in the state.

Throughout Rajasthan, high poverty levels promoting sex work, geographic dispersion of the population, low levels of literacy (particularly among women), repeated droughts encouraging within state and out-of-state migration, reticence to seek STI treatment, and the low status of women are all contributing factors which are facilitating the spread of HIV in Rajasthan.

8.2 INSTITUTIONAL RESOURCES AND RESPONSES

8.2.1 Overview

HIV prevention and control activities in Rajasthan are largely under the direction of the Rajasthan State AIDS Control Society (RSACS). RSACS was established in December 1998 under the Chair of the Health Secretary of the state. Its governing body includes both government and NGO representatives but, as yet, no person living with HIV/AIDS. At the district level, the District Chief Medical and Health Officer has been designated the nodal officer for implementation of the program. In its first year of operation RSACS experienced difficulties in creating efficient administrative structures to distribute funds from the NACP-I and NACP-II. No NGOs have received support since the inception of RSACS. A variety of NGOs responded to two calls for proposals for prevention and control activities and with the recent hiring of an NGO advisor, the process of selection of NGOs and disbursement of funds is underway. The RSACS organizational chart shows many unfilled positions, and other than that of the NGO advisor, the five filled posts are occupied by individuals deputized from the state government, several of whom have other significant other responsibilities.

8.2.2 Opportunities for Capacity Building

Following consultations with RSACS, NGOs and other institutional partners during the Rajasthan site visits, several strengths and opportunities for capacity building in Rajasthan's response to the HIV epidemic are evident. The strengths include:

- The leadership and knowledge of the Secretary of Health and the Project Director.
- The commitment and skills of the deputy director, NGO advisor and other RSACS staff (with whom site visits were conducted).
- The evident concern and willingness to contribute in a meaningful way shown by a number of NGO partners.
- The caring and sensitivity of the clinicians delivering AIDS care.
- The provision of non-discriminatory in-patient care in state institutions.
- The safety of the blood bank program.
- The extent of training sessions that have been held for health sector personnel.

The opportunities for capacity building include:

- Increasing the involvement of PLWHA in RSACS.
- Gathering population-based information about sexual behaviour among vulnerable populations and in the general population.
- The ability of NGOs to develop high quality community-based prevention and care programs.
- The creation of an enabling environment for HIV/AIDS programming.
- The creation of integrated models for implementation linking prevention activities with care and support activities at the community level.

8.3 RAJASTHAN COMPONENT PROJECT DESCRIPTION

8.3.1 Overview

Based on the design team's consultations and participatory identification of strengths and opportunities with RSACS, a program plan to improve the capacity in Rajasthan to respond to the epidemic was developed. The two main program components are:

1) Capacity building of RSACS and its implementing partners.

2) Implementation and rigorous evaluation of novel high quality demonstration projects.

Capacity building for RSACS and implementing partners (component 1) will be primarily through technical inputs into the planning, implementation and evaluation of HIV prevention, care and support activities. Through the implementation of high quality demonstration projects, the project will work with NGOs and other implementing partners to develop, evaluate and disseminate effective strategies for HIV prevention, care and support. Through this mechanism, the project will build the capacity of implementers, provide opportunities for applied training, and provide insights and innovations for replication throughout Rajasthan and in other states.

8.3.2 Work Breakdown Structure

The work breakdown structure (WBS) for activities in Rajasthan has two components. The first component (R1000) is "Capacity Building for RSACS and Implementers, State Level". There are three main outputs for this component with associated activity streams. The second component (R2000) is "Implementation of Demonstration Projects", which has activities organized under three main outputs. These activity streams are summarized in the figure below. The detailed activities under each of these streams are described in the following sections.

Component R1000 – Capacity Building for RSACS and Implementers, State Level

- **Output R1100** – Improved RSACS' and implementers' capacity to gather, analyze and integrate information into decision making.
- **Output R1200** – Enhanced RSACS' and implementers' capacity to mobilize, monitor and evaluate evidence-based HIV/AIDS programming.

- **Output R1300** – Enhanced RSACS' and implementers' capacity to create an enabling environment for HIV/AIDS programming.

Component R2000 – Implementation of Demonstration Projects

- **Output R2100** – Development and implementation of a community-based participatory intervention for rural migrant men.
- **Output R2200** – Development and implementation of a community-based participatory intervention for rural caste-based sex work.
- **Output R2300** – Development and implementation of a Rajasthan model of the prevention-care continuum.

Component R1000 Capacity Building for RSACS and Implementers – State Level		
R1100 Improved RSACS' and implementers' capacity to gather, analyze & integrate information into decision making	**R1200** Enhanced RSACS' and implementers' capacity to mobilize, monitor & evaluate evidence-based HIV/AIDS programming	**R1300** Enhanced RSACS' and implementers' capacity to create an enabling environment for HIV/AIDS programming
R1101 Train RSACS & implementers in rapid epidemiologic assessment **R1102** Train & assist RSACS & implementers in collection and analysis of information on STI/HIV, behaviours, and gender & development indicators **R1103** Train and assist RSACS and implementers in conducting situational analysis and needs assessments **R1104** Train & assist RSACS in conducting directed research for advocacy and policy formulation **R1105** Train and assist implementers in conducting operational research for program formulation and implementation **R1106** Train and assist RSACS and implementers in monitoring and evaluating program outcome and impact **R1107** Train RSACS and implementers in population-based strategic planning of HIV programs	**R1201** Train RSACS and implementers in best practices in delivery of targeted HIV/AIDS programming **R1202** Train and assist implementers for innovative participatory peer group interventions with vulnerable populations **R1203** Assist RSACS and implementers in the dissemination and scaling up of effective HIV/AIDS programs **R1204** Train and assist RSACS and implementers in the development of appropriate voluntary counseling and testing **R1205** Train and assist RSACS and implementers to establish effective STI management at the "grassroots" level **R1206** Train and assist RSACS and implementers to integrate prevention, care and support along a continuum	**R1301** Assist RSACS and implementers to increase the awareness, sensitivity and capacity of public & private sector policy makers and community leaders on HIV/AIDS issues **R1302** Assist RSACS and implementers to involve PLWHAs and vulnerable groups in all aspects of program design, implementation and evaluation of prevention, care and support programming **R1303** Assist RSACS and implementers to incorporate HIV/AIDS issues into development, social & gender issues **R1304** Train and assist RSACS and implementers to develop effective policy and practice for occupational safety of health professionals **R1305** Assist RSACS and implementers to effectively link prevention to care and support activities **R1306** Develop effective and appropriate training materials and methods

Component R2000 Implementation of Demonstration Projects		
R2100 Development of a community-based participatory intervention for rural migrant men with partners	**R2200** Development of a community-based participatory intervention for rural caste-based sex work with partners	**R2300** Development of a Rajasthan model of the prevention-care continuum
R2101 Identify community of rural migrant men for intervention **R2101** Train and mobilize NGOs and other implementing partners **R2103** Conduct baseline assessment of migrant population **R2104** Train peer educators and supervisors **R2105** Implement interventions using an iterative approach **R2106** Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices **R2107** Provide resources and opportunities for hands-on training for other implementers in interventions **R2108** Expand intervention to networked communities	**R2201** Identify community or area for intervention **R2201** Train and mobilize NGOs and other implementing partners **R2203** Conduct baseline assessment of intervention population **R2204** Train peer educators and supervisors **R2205** Implement interventions using an iterative approach **R2106** Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices **R2207** Provide resources and opportunities for hands on training for other implementers in interventions **R2208** Expand intervention to networked communities	**R2301** Conduct a needs assessment and determine model site **R2302** Identify and review best practice models that could be adapted **R2303** Design and implement the model project using a participatory approach **R2304** Develop mechanisms for the ongoing evaluation of the model **R2305** Document and disseminate lessons learned and project impact **R2306** Provide resources and opportunities for hands-on training for other implementers

8.3.3 *Description of Outputs and Activities*

Component R1000 – Capacity Building for RSACS and Implementers – State Level

In this component of the program, a number of strategies will be used to strengthen the capacity of RSACS and its implementing partners at the state level. These strategies will include:

Technical Assistance/Mentoring: A network of Canadian and international technical specialists will provide direct technical advice, consultation and mentoring for members of RSACS and implementing agencies. Local Indian technical expertise will also be engaged to offer the same opportunities.

Needs-based Training: Where necessary, direct training for RSACS members and implementers will be provided, using high quality and validated training materials and methods. This training will involve both short courses and training workshops.

Study Tours and International Linkages: There are many examples of high quality HIV/AIDS prevention, care and support programs both in India and elsewhere. Mechanisms will be developed for linking RSACS and its implementing partners to these programs, such as through organization and support for study tours, to promote the use of national and international best practices.

Strengthening Facilities and Funding Selected Initiatives: Direct support will be provided for the strengthening of selected facilities that can serve as state-wide resources. For example, this could include the strengthening of a designated facility for the diagnosis of STIs, in support of enhanced STI surveillance and validation of syndromic management guidelines.

Outputs and Activities

The outputs and specific activities under Component R1000 are described below.

Output R1100 – Improved RSACS' and implementers' capacity to gather, analyze and integrate information into decision making.

Activity R1101 – Train RSACS and implementers in rapid epidemiologic assessment.

Rapid epidemiologic assessment (REA) includes a set of methods and tools that can be used to quickly assess a population's situation with respect to the prevalence and incidence of HIV infection and other STIs, and the transmission dynamics of HIV/STIs in a community. Thus, improving RSACS' and implementers' capacity to perform REA can support the formulation of HIV prevention strategies. Training activities will include:

R1101.1 – Prepare and convene training sessions and workshops on REA with designated RSACS representatives and members of implementing organizations and academic institutions.

R1101.2 – With RSACS and implementers, develop appropriate tools for REA that can be used in various settings throughout the state.

R1101.3 – Assist RSACS and implementers to undertake REAs in key population groups or districts where required.

Activity R1102 – Train and assist RSACS and implementers in the collection and analysis of information on STI/HIV, behaviours, and gender and development indicators.

In addition to REA, organized and ongoing systems for the collection and analysis of population-level information on the prevalence and incidence of STI/HIV, risk behaviours and other parameters are necessary to describe the burden of illness related to STI/HIV, to identify at-risk populations, and to monitor the impact of prevention efforts. Activities to enhance capacity in this area will include:

R1102.1 – Establish a state level Working Group to develop information priorities, review existing information systems, develop a strategic plan for information collection, analysis and dissemination, and develop methods and tools for information gathering and epidemiologic surveillance. The Working Group will be resourced by the Technical Support Unit (TSU) and will include membership from the TSU, RSACS, NGOs, medical and academic institutions, and the community (including PLWHAs).

R1102.2 – Provide training in quantitative and qualitative methods for the collection, analysis and interpretation of relevant population information through workshops and field experiences.

R1102.3 – Under the guidance of the Working Group, establish pilot systems for information gathering, including surveys and disease surveillance.

Activity R1103 – Train and assist RSACS and implementers in conducting situation analyses and needs assessments.

To plan and implement effective HIV programming, there must be the capacity to conduct high quality situation analyses and needs assessments. This process involves analyzing and integrating information regarding the status and drivers of the HIV epidemic in the population, understanding the various intervention options and their rationale, and critically reviewing the available resources and resource gaps. To enhance capacity in this area the following activities will be undertaken.

R1103.1 – Provide training for RSACS and its implementing partners in the conduct of situation analyses and needs assessments. This training would include the convening of workshops and the development of training materials.

R1103.2 – With RSACS and its implementing partners, identify priority regions and populations, and formulate plans for and assist in conducting situational analyses and

needs assessments in those areas. These assessments would be used to provide hands-on training opportunities.

Activity R1104 – Train and assist RSACS in conducting directed research for advocacy and policy formulation.

Policy decisions are key to creating an enabling environment and ensuring that the most effective interventions are given priority. Evidence from relevant research can be a valuable tool for selecting and advocating policy directions. For example, it can be used to estimate the population impact and cost- effectiveness of various intervention options.

R1104.1 – Together with RSACS, a set of policy-relevant research questions will be developed and addressed. Technical expertise will be provided to conduct the research and to provide consultation to RSACS on the process and implications of the findings.

Activity R1105 – Train and assist implementers in conducting operational research for program formulation and iterative implementation.

Operational research is directed at assessing the processes and impacts of programmatic activities. The results of this kind of research are beneficial because they identify ways by which the efficiency and effectiveness of programs can be improved.

R1105.1 – Training in operational research will be delivered through workshops and hands-on training experiences.

R1105.2 – With RSACS and implementers, an agenda for operational research will be developed that focuses on important intervention activities in the state. Subsequently, operational research projects will be jointly developed and the results integrated into program formulation and implementation.

Activity R1106 – Train and assist RSACS and implementers in monitoring and evaluating program outcomes and impacts.

Program monitoring and evaluation is necessary to ensure that programmatic activities are using efficient processes and achieving desired results.

R1106.1 – Direct training will be provided for RSACS and implementers in the conduct of program monitoring and evaluation through workshops and hands-on training.

R1106.2 – With RSACS and its implementing partners, systems for monitoring and evaluating key state level programs will be developed.

Activity R1107 – Train RSACS and implementers in population-based strategic planning of HIV programs.

To maximize the impact and cost-effectiveness of HIV/AIDS program activities, planning should be strategic, evidence-based and appropriate to the local population situation. The following activities will be undertaken to enhance capacity in this area.

R1107.1 – Provide direct training for RSACS and implementers in strategic planning.

R1107.2 – Convene strategic planning workshops that involve RSACS, implementers, community participants and other key stakeholders.

Output R1200 – Enhanced RSACS' and implementers' capacity to mobilize, monitor and evaluate evidence-based HIV/AIDS programming.

Activity R1201 – Train RSACS and implementers in best practices in delivery of targeted HIV/AIDS programming.

There are many examples of excellent programs that are delivering targeted HIV/AIDS interventions in India and elsewhere that could be described as representing best practice in the field. The capacity of RSACS and implementers to deliver targeted interventions will be strengthened by increasing their knowledge of these high quality programs.

R1201.1 – Review and summarize examples of best practices in India and elsewhere and translate this information to RSACS and implementers through structured meetings and workshops. This process will include reviewing and disseminating best practice documentation from national Technical Resource Groups.

R1201.2 – Arrange for interaction between RSACS and implementing partners and best practice programs by convening joint meetings and supporting study tours.

Activity R1202 – Train and assist implementers for innovative participatory peer group interventions with vulnerable populations.

R1202.1 - Provide technical training to RSACS, NGOs and other implementers in executing peer education programs. This would include training on the rationale for targeted interventions, the methodology for selecting target sites and zones and for recruiting peer educators, and the importance of focus and intensity. It would also include how to conduct baseline surveys and formative assessments, how to develop and use participatory methods and materials, how to train peer educators to train their peers and how to monitor program outputs for the duration of the program. Such training expertise can be sourced within India or internationally.

R1202.2 - Provide technical assistance to NGOs implementing peer group interventions. Follow-up technical support would be provided to the NGOs who receive the initial training. Such technical support would include the provision of support in carrying out

comprehensive mapping and zoning exercises, designing formative and baseline assessment tools, recruiting and training peer educators, and in developing a range of participatory educational materials. Support would also be provided to NGOs in developing and designing monitoring and evaluation indicators and related data collection tools.

R1202.3 – Initially, the project, in partnership with RSACS, implementers and target groups, will jointly develop processes and indicators of empowerment for vulnerable target populations. In the interests of sustainability and community ownership, work with vulnerable populations will try to emulate the lessons learned by the Sonagachi project. Sonagachi is now largely run by the sex workers themselves and has extended the range of issues addressed to include such social issues as legal reform, literacy and affirming sexuality. An exchange visit involving RSACS, implementers and sex workers will help inform this process.

Activity R1203 – Assist RSACS and implementers in the dissemination and scaling up of effective HIV/AIDS programs.

As effective programs are developed by implementers in specific populations, an important challenge is to disseminate the knowledge and scale up capacity across the state.

R1203.1 – Working with RSACS and implementing partners, effective programs will be reviewed and documented. This information will then be shared with implementers in other parts of the state through written documentation, and presentations at meetings and conferences.

R1203.2 – Workshops or symposiums will be convened to promote interaction and the sharing of experiences between implementers that are already engaged in effective programming and those that are at an earlier stage of implementation.

Activity R1204 – Train and assist RSACS and implementers in the development of appropriate voluntary counseling and testing services.

R1204.1 - Conduct initial VCT training for RSACS and implementers.

R1204.2 - In partnership with RSACS and implementers, conduct a review of VCT services in the public and private sectors in Rajasthan State. Identify strengths and weaknesses and develop an agreement within RSACS and health institutions regarding the steps required to improve existing VCT services.

R1204.3 - Following the review of VCT services, develop an agreement with RSACS and partners regarding the expansion of cost-effective, quality VCT services in Rajasthan.

R1204.4 - Provide pre and post-test HIV counseling training for RSACS and relevant staff in key health institutions providing VCT. Such training would include a review of the legal framework in India for HIV testing, the key components of pre and post-test

counseling, the vital importance of informed consent and confidentiality (individual or shared) regarding test results, and follow-up counseling support and referral for HIV positive clients.

R1204.5 - Provide feedback to the HIV/AIDS forum (cf. R1301.1) regarding findings, conclusions and recommendations on VCT in Rajasthan State.

Activity R1205 – Train and assist RSACS and implementers to establish effective STI management at the "grassroots" level.

R1205.1 - Conduct initial STI syndromic management training for RSACS and relevant partners.

R1205.2 - In collaboration with RSACS and its key partner health institutions, conduct a review of STI management in Rajasthan. Assess the extent to which STI treatment is laboratory dependent or syndromic, stigmatized or freely used by men and women. Provide feedback to the RSACS Management Committee on key findings. Develop an agreement within RSACS and the health sector regarding the institutions to which STI management should be initially devolved (for example, primary health care centers, district hospitals, family planning services, and/or gynecologists).

R1205.3 – Provide information for RSACS and partners regarding the required technical supports for STI management such as simple algorithm flow-charts, drug lists for syndromic management of STI and a drug record card, partner referral cards, penile models and condoms, an examination couch and a separate room for carrying out the physical exam and counseling. Provide technical support to RSACS and the health sector in developing the foregoing supports, and well as relevant back-up laboratory services.

R1205.4 - Train the trainers from targeted health institutions to provide the following training: syndromic management, supervision of syndromic management and counseling skills.

R1205.5 - Assist health facilities to set up an STI treatment reporting system within the health sector with information transfer to RSACS.

R1205.6 - Assist RSACS in carrying out training of health providers. Provide ongoing technical support in the implementation of all the foregoing.

Activity R1206 – Train and assist RSACS and implementers to integrate prevention, care and support along a continuum.

A key challenge in HIV/AIDS programming is the integration of a wide range of activities from prevention to care and support. This type of integration is beneficial since the various activities are mutually supportive and the complementary strengths of various implementers can be promoted. Training of RSACS and implementers in this activity will rely on lessons learned through the continuum of care demonstration project.

R1206.1 – Integrated activities in the continuum of care demonstration project will be documented and communicated to RSACS and implementing partners.

R1206.2 – Visits to the demonstration project to review the integrated model will be arranged for RSACS and implementers.

Output R1300 – Enhanced RSACS and implementers' capacity to create an enabling environment for HIV/AIDS programming.

Activity R1301 – Assist RSACS and implementers to increase the awareness, sensitivity and capacity of public and private sector policy makers and community leaders on HIV/AIDS issues.

R1301.1 - Set up a state level HIV/AIDS forum for policy makers. This forum would be made up of senior government, public and private health sector, research and NGO personnel. The purpose of this forum would be to review and discuss HIV policy and program issues with a focus on inter-sectoral linkages, and to educate policy makers regarding HIV/AIDS issues. The forum would be convened a minimum of twice yearly by RSACS and would set priorities for its work, review up-to-date research and information within priority programming areas and advise on problem areas as they arise. The forum would be convened by RSACS. Preparing materials for the forum's consideration and input would be the joint responsibility of RSACS and the project. To the fullest extent possible the forum will be made up of both men and women and have representation from women's organizations. Policy makers from the demonstration project areas would also participate in the forum.

R1301.2 - An information newsletter/bulletin will be produced by the project at least twice a year. This newsletter/bulletin will cover areas of relevance to HIV/AIDS policy and program frameworks for HIV/AIDS prevention and care. Gender issues will be integrated. This newsletter could be produced jointly with the Karnataka office.

R1301.3 - Sensitize community leaders to HIV/AIDS issues. In order to work at the community level, it is vital to have the support of local community leaders. Ignored or poorly educated community leaders can sabotage an initiative's best efforts if their understanding and support has not been solicited in advance. The project will provide technical assistance to RSACS and NGOs in understanding the importance of sensitizing community leaders, in how to identify relevant community leaders for sensitization, and in the provision of educational materials/talks to such leaders. One appropriate mechanism for providing technical support to the NGOs is through the RSACS' NGO network.

Activity R1302 – Assist RSACS and implementers to involve PLWHAs and vulnerable groups in all aspects of program design, implementation and evaluation of prevention, care and support programming.

The involvement of PLWHAs and vulnerable groups in the design and implementation of HIV/AIDS programming helps to ensure that programming is appropriate, effective and sensitive to the needs of those most affected by the programs.

R1302.1 – The Project will include PLWHAs and affected vulnerable groups in all aspects of the design and implementation of its program activities, thus providing a model for other implementing agencies.

R1302.2 – Meetings and workshops will be convened to engage PLWHAs and vulnerable populations in focused discussions regarding programmatic needs and policy issues related to HIV/AIDS.

Activity R1303 – Assist RSACS and implementers to incorporate HIV/AIDS issues into development, social and gender issues.

R1303.1 - This component is designed to work with organizations not directly involved with RSACS or the project. Therefore, the first task will be to map the range and type of organizations that exist. The second task will be to understand how people are currently being educated about HIV/AIDS transmission and how their current HIV-related care and support needs are being met. The third task will be to identify organizations with potential and interest in collaborating with RSACS and the project. Ranges of social change, development and gender initiatives exist in both rural and urban Rajasthan. The project will encourage RSACS' implementers to work with a selected number of these initiatives. This is in order to promote HIV/AIDS education and prevention within these organizations and to link to service organizations providing a continuum of care for those who are sick, dying or orphaned. This can be accomplished in a number of ways.

R1303.2 - One strategy for integrating HIV/AIDS issues into social change, development and gender initiatives is through strengthening the existing RSACS NGO network and bringing members together with a view to sharing information with each other. This information could include identifying which organizations have potential for networking. The RSACS NGO network could then develop strategies for expanding their HIV prevention efforts through such organizations and at the same time carry out advocacy and HIV information provision among service providers relevant for HIV-related prevention, care and advocacy.

R1303.3 - Another strategy for integrating HIV/AIDS issues into social change, development and gender initiatives is to encourage RSACS' NGO implementers to participate in other NGO coalitions and advocacy groups addressing development, social change and gender issues, e.g. FEVORD (rural development NGO network). The idea would be to provide a voice for HIV/AIDS issues and to advocate for the inclusion of HIV issues in information and advocacy agendas, for example, human rights organizations and reproductive health organizations. In addition, HIV/AIDS

implementers' participation in other coalitions could provide an advocacy forum to encourage service providers not to turn away PLWHAs.

R1303.4 - Another strategy would be to encourage NGOs implementing HIV prevention and care programs to liaise directly with certain groups on a one-to-one basis.

R1303.5 - To support the above activities the project would help the NGO network to develop relevant information and advocacy materials. These could include simple one-page fact sheets on a range of HIV-related issues in order to support their advocacy and information sharing agenda. Such fact sheets could include for example, the urgency of preventing HIV in India, how a person can and cannot become infected with HIV, HIV as a reproductive health issue, the care and support needs of PLWHAs, myths concerning HIV, etc. It is anticipated that this component will start up sometime after the second year of the project.

Activity R1304 – Train and assist RSACS and implementers to develop effective policy and practice for occupational safety of health professionals.

R1304.1 - The convening of an expert committee drawn from the Indian health sector (public and private) can best effect the development of an occupational safety policy on HIV for health professionals. In addition, project staff and RSACS representatives would also participate on this committee. Such a committee should include both doctors and nurses. This committee could make its initial recommendations to the policy forum and the RSACS Management Committee.

R1304.2 - Any policy developed should be context-specific and realistic, and address the real and perceived risks of health workers. Such a policy should keep in mind the cost of universal precautions versus discrete use of such precautions – gloves, for example – and the likely stigmatization of PLWHAs arising from such use. Such a policy should also address the very real risk of tuberculosis infection and the precautions necessary for its prevention among health workers. Given that blood and body fluid exposure during the delivery of newborns is one area of grave concern to heath workers, specific attention should be given to this issue.

R1304.3 - In order to promote the occupational safety of health professionals, they first need to thoroughly understand how they are and are not at risk. Then they need to be guided by their health facility's policy on occupational safety and HIV, and be supervised in ensuring that adequate, but non-discriminatory precautions are taken. Some training on occupational safety and HIV for health workers and their supervisors will be required. Therefore, the project will assist RSACS in the development of training materials on occupational safety and HIV.

Activity R1305 – Assist RSACS and implementers to effectively link prevention to care and support activities.

R1305.1 - Emerging best practices from around the world indicate that at the level of vulnerable communities at least, sustainable success is associated with integrated programming. Two examples are the link between HIV testing and PLWHA support groups, and care and support for peer educators who have worked to promote safer sex practices who become sick and/or leave orphaned children behind when they die. Building an environment where people feel safe to be tested for HIV requires more than clean needles and test kits. It requires some change in legal frameworks, employment laws, counseling support and the support of others living with HIV. Building sustainable community responses to HIV prevention and care requires a strong link between the two from the outset. The more cared for a person with HIV feels, the better chance she or he will care about infecting others.

R1305.2 - The project will encourage RSACS to make strong policy and program links between prevention and care. This will be done initially by providing input to the policy forum and the RSACS Management Committee. This input will be based on two elements, a literature review of experiences from other countries and from within India, and working with RSACS' implementing partners to document their experiences to date in the link between prevention and care. Finally, the demonstration project experience will actively link prevention and care programming, and these experiences and lessons learned will be available to RSACS by the fourth and fifth years of the Project.

Activity R1306 – Develop effective and appropriate training materials and methods.

R1306.1 - The Project Office will constitute a technical resource to RSACS and implementing partners. The project will hire a training materials development expert, and where necessary help produce a range of training manuals and materials for program implementers. One of the first tasks for the project will be to identify the training to be carried out within each program area and the support materials needed for this training. Possible training courses/materials include, Syndromic Management of STI, STI/HIV Counseling Skills for Health Workers, STI/HIV Supervision Skills for Health Workers, Home-based Care for People with HIV/AIDS, Mobilizing and Training Vulnerable Groups, and HIV and Gender. Training materials could also include materials and methods developed for peer educators with low literacy skills working in low literacy environments. Many of the above training manuals have already been developed in India or elsewhere. Such manuals may be adapted in a culturally and linguistically appropriate way. Negative gender stereotypes will not be reinforced in any of these training materials. Technical assistance can be provided from within and without India.

Component R2000 – Implementation of Demonstration Projects

In this component, the project will implement three demonstration projects in Rajasthan addressing three specific programming needs. These projects will have a focus on social phenomena important in HIV prevention and care rather than a geographic focus. The projects will be rigorously monitored and evaluated so that they can serve as models that can be

replicated in other districts across the state and in other states. Sites for implementation will be selected based on discussions with the RSACS and criteria including HIV prevalence, vulnerability to HIV, geographical location, strengths of potential NGO partners, availability of basic infrastructure, and motivation and interest of the community.

The first demonstration project will focus on rural migrant men and the second on caste-based female sex worker villages. The rationale for selecting these populations is that both are likely to be important in the spread of HIV and there are few examples of innovative programs for these populations in India. These two projects will be geographically and operationally linked. There are several reasons for using this approach. First, by focusing on prevention at the rural level in the first project, we will be able to gain and share insights into the processes, costs and impacts of various activities at the rural level where the majority of the Rajasthan population lives and where few HIV/AIDS prevention efforts are underway. Second, caste-based sex work is an important phenomenon in Rajasthan and there have been few successful attempts to engage these groups in HIV/AIDS prevention. Furthermore, the linkages of sex worker villages to others provides a natural route for later expansion. Finally, it allows the project to concentrate resources in a way that maximizes the ability to build capacity through the transfer of skills and knowledge regarding HIV prevention, care and support.

The third demonstration project will be to develop a model of the prevention-care continuum. For this pilot project, a site will be selected in conjunction with RSACS and its implementing partners. The goal will be to create a model that demonstrates the processes and benefits of linking HIV-related program activities along a continuum from prevention to care. This model will be evaluated and documented so that lessons learned can then be disseminated to other sites in Rajasthan and in other states.

These demonstration projects will provide a venue for the provision of high quality, hands on training for implementers who may then serve as resources for the training and mentoring of other implementers in prevention, care and support activities. Selection of the populations for implementation of the demonstration projects will be based upon discussions with RSACS, NGOs and other implementing partners, and community groups.

Outputs and Activities

Output R2100 – Implementation of a community-based participatory intervention for rural migrant men.

Activity R2101 – Identify community of rural migrant men for intervention.

R2101.1 - In partnership with RSACS, NGOs and other implementers, and community groups, identify the community and site for the demonstration project.

R2101.2 - Identify and assess relevant NGOs working in the area. Select NGO implementers.

Activity R2102 – Train and mobilize NGOs and other implementers.

R2102.1 - Provide training for NGOs and other implementing partners in basic issues regarding HIV transmission, the epidemiology of HIV, and the rationale for targeted interventions. NGO training would also include the following: how to map and zone target areas, how to mobilize vulnerable groups, how to select and train peer leaders, how to support peer leaders in their ongoing work of promoting partner number reduction, condom use, STI care and support referral, and finally, how to monitor and evaluate their work.

Activity R2103 – Conduct baseline assessments of rural migrant population.

R2103.1 - Design survey tools for rural migrant men and their sexual partners, including sex workers. Ensure that questions regarding attitudes to men and women and sexuality are included as well as basic questions concerning sexual behaviour and knowledge about STI/HIV transmission and prevention.

R2103.2 - Pre-testing of survey tools by NGOs/implementers.

R2103.3 – Surveys of the target community by NGOs/implementers.

R2103.4 – Processing and analysis of survey data by project/NGOs/implementers.

Activity R2104 – Train peer educators and supervisors.

R2104.1 - With NGOs and other implementers, agree on selection criteria for peer educators.

R2104.2 – Mentor NGOs/implementers in selection of peer educators . Each peer educator to be responsible for 50 peers.

R2104.3 - Assist NGOs/implementers in training of peer educators by providing training materials and selected training support to NGOs/implementers.

R2104.4 – Agree on what, if any, remuneration or other considerations to be provided to the peer educators.

R2104.5 - Equip peer educators with participatory education materials, group registers, and checklists to register attendance, topics discussed, number of condoms distributed, number of STI referrals and other areas of concern to the group.

R2104.6 - Ensure that NGOs/implementers collect and compile peer educator data on a monthly basis.

Activity R2105 – Implement interventions using an iterative approach.

R2105.1 – Mentor NGO Staff and peer educators' collaboration in health promotion activities and empowerment activities among target groups.

R2105.2 – Assist NGO staff and peer educators in establishing and maintaining effective peer group structure, dynamics and organization by ensuring appropriate monitoring and supervisory tools are in place, and adequate supplies (of condoms and other materials) are available. Encourage groups to organize around issues of common concern, whether directly HIV related or not. Peer leaders may be issued with T-shirts and receive a small monthly stipend.

R2105.3 - Assist NGO staff in supporting peer leaders in their functions by advising on the development of specific educational approaches (one-minute sketches, role-plays).

R2105.4 – Train NGO Staff to respond to emerging needs and problems of the peers or their groups and resolve conflicts.

R2105.5 – Plan, conduct and analyze surveys of the impact of the demonstration project on sexual attitudes and behaviour and other indicators in target groups.

Activity R2106 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices.

A key objective of the demonstration projects will be to determine the impact of programming and to disseminate innovations and lessons learned to other implementers across the state.

R2106.1 – Establish a system of evaluation and monitoring activities to assess inputs, costs, processes and impacts.

R2106.2 – Collect, process and analyze data for monitoring and evaluation.

R2106.3 – Create written documentation of processes and summaries of the outcomes and impacts in written reports.

R2106.4 – Disseminate innovations and lessons learned through written communications and workshops for policy makers and implementers.

Activity R2107 – Provide resources and opportunities for hands on training for other implementers in interventions.

The demonstration project will provide excellent opportunities for training program planners and implementers from across the state. Once the demonstration project is operational these opportunities will be promoted.

R2107.1 – Develop training manuals and materials based on the demonstration project activities.

R2107.2 – Train leaders in the demonstration project to provide hands-on training for personnel from various implementing agencies.

R2107.3 – Provide hands-on training programs within the demonstration project.

Output R2200 – Implementation of a community-based participatory intervention for rural caste-based sex work.

Activity R2201 – Identify community for intervention.

R2201.1 - In partnership with RSACS, NGOs and other implementers, and community groups, identify the population for the demonstration project.

R2201.2 - Identify and assess relevant NGOs working in the area as potential partners. Develop partnership with NGO implementers.

Activity R2202 – Train and mobilize NGOs and other implementers.

R2202.1 - Provide training for NGOs and other implementing partners in the basic issues regarding HIV transmission, the epidemiology of HIV, and the rationale for targeted interventions. NGO training would also include the following: how to map and zone target areas, how to mobilize vulnerable groups, how to select and train peer leaders, how to support peer leaders in their ongoing work of promoting partner reduction, condom use, STI care and support, referral, and finally, how to monitor their work.

Activity R2203 – Conduct baseline assessments of all aspects of caste-based sex work.

R2203.1 – Conduct an ethnographic and epidemiologic assessment of rural caste-based sex work. Ensure that the assessment addresses issues regarding the social and cultural aspects as well as basic questions concerning sexual behaviour and knowledge about STI/HIV transmission and prevention.

R2203.2 – Pre-testing of survey tools by NGOs/implementers.

R2203.3 – Survey of target community by NGOs/implementers.

R2203.4 – Processing and analysis of data by project/NGOs/implementers.

Activity R2204 – Train peer educators and supervisors.

R2204.1 - With NGOs and other implementers, agree on selection criteria for peer educators.

R2204.2 – Mentor NGOs/implementers in selection of peer educators. Each peer educator to be responsible for 50 peers.

R2204.3 – Assist NGOs/implementers in training of peer educators by providing training materials and selected training support to NGOs/implementers.

R2204.4 - Agree on what, if any, remuneration or other considerations to be provided to the peer educators.

R2204.5 - Equip peer educators with participatory education materials, group registers, and checklists to register attendance, topics discussed, number of condoms distributed, number of STI referrals and other areas of concern to the group.

R2204.6 - Ensure that NGOs/implementers collect and compile peer educator data on a monthly basis.

Activity R2205 – Implement interventions using an iterative approach.

R2205.1 - Mentor NGO Staff and peer educators' collaboration in health promotion activities and empowerment activities among target groups.

R2205.2 - Assist NGO Staff and peer educators in establishing and maintaining effective peer group structure, dynamics and organization by ensuring appropriate monitoring and supervisory tools are in place, and adequate supplies (of condoms and other materials) are available. Encourage groups to organize around issues of common concern whether directly HIV-related or not. Peer leaders may be issued with T-shirts and receive a small monthly stipend.

R2205.3 - Assist NGO staff in supporting peer leaders in their functions by advising on the development of specific educational approaches (one-minute sketches, role-plays).

R2205.4 - Train NGO staff to respond to emerging needs and problems of the peers or their groups and resolve conflicts.

R2205.5 - Plan, conduct and analyze a survey of the impact of the demonstration project on sexual attitudes and behaviours and other indicators in target groups in the last year of the project.

Activity R2206 – Evaluate outcomes and impacts, and disseminate innovations, lessons learned and best practices.

A key objective of the demonstration projects will be to determine the impact of the programming and to disseminate innovations and lessons learned to other implementers across the state.

R2206.1 – Establish a system of evaluation and monitoring activities to assess inputs, costs, processes and impacts.

R2206.2 - Collect, process and analyze data for monitoring and evaluation.

R2206.3 – Create written documentation of processes and summaries of the outcomes and impacts in written reports.

R2206.4 – Disseminate innovations and lessons learned through written communications and workshops for policy makers and implementers.

Activity R2207 – Provide resources and opportunities for hands-on training for other implementers in interventions.

The demonstration project will provide excellent opportunities for training program planners and implementers from across the state. Once the demonstration project is operational these opportunities will be promoted.

R2207.1 – Develop training manuals and materials based on the demonstration project activities.

R2207.2 – Train leaders in the demonstration project to provide hands-on training for personnel from various implementing agencies.

R2207.3 – Provide hands-on training programs within the demonstration project.

Output R2300 – Development of a Rajasthan model of the prevention-care continuum.

Emerging best practices from around the world indicate that sustainable success in addressing the determinants and consequences of the HIV epidemic depends on integrated programming linking prevention and care. Examples include creating strong ties between voluntary counselling and testing (VCT) and PLWHA support groups, and engaging PLWHAs in community-based prevention activities. Building an enabling environment where people feel safe to come forward to be tested for HIV requires changes in legal frameworks, including employment laws, to counter discrimination and the creation of supportive networks facilitating counselling and peer support by others living with HIV. Building sustainable community responses to HIV prevention and care requires a strong link between the two from the outset. People can then realize that finding out one's HIV status is the first step to living positively, allowing healthy choices to be made to the extent possible concerning nutrition, prophylaxis for opportunistic illnesses, stress reduction, and permitting informed reproductive health decision-making and ongoing participation in community activities without discrimination or marginalization. Others then will be encouraged to come forward for voluntary counseling and testing. Learning one's HIV status is the first step towards adopting prevention practices to avoid infecting others.

The project will encourage RSACS to make strong policy and program links between prevention and care at all levels and in various aspects of the program. A demonstration project initially operating in one site will link VCT with facilitation of the establishment of both support groups for people living with HIV/AIDS and home-based care. This project aims to develop an affordable integrated model of care and support that will strengthen community and family coping mechanisms and ultimately encourage more people to come forward for VCT and learn positive living skills if they test positive. Elements of the program will include family counseling and identification of key family members for training in home-based care, nutritional advice and supplementation, and care and support for HIV-related disease and other health and psycho-social problems. The care continuum, which will include outpatient care, day care, acute care, and home care, is not linear in nature because of the alternating illness/remission cycles of HIV-related disease. Rather, it is holistic in encompassing the physical, emotional, spiritual and social needs of the patient and in aiming to provide comprehensive care, support and comfort at all stages of HIV-related disease.

Activity R2301 – Conduct a needs assessment and determine the model site.

R2301.1 – Conduct a needs assessment of the continuum of care in Jaipur, Jodhpur and Udaipur to determine where the first pilot project should be situated. Selection criteria will include: prevalence of HIV disease, availability and accessibility of current VCT services, physician interest in working in the continuum of care model, attitudes of health care providers to the concept of a shared care model, potential for establishment or strengthening of support groups for PLWHAs, availability of mentors to teach counseling skills to volunteers, and the potential for creating a non-stigmatizing, caring and confidential environment.

R2301.2 – Document the current situation in the selected sites by collecting data through key informant interviews and focus groups and by using available data sources for information on local epidemiology, hospital bed occupancy rates, profiles of clinical disease patterns and current care practices.

Activity R2302 – Identify and review best practice models that could be adapted.

R2302.1 – Conduct a comprehensive literature review including guidelines for comprehensive care developed by organizations such as NACO, WHO and Horizons.

R2302.2 – Conduct site visits to care models in other parts of India.

R2302.3 – Conduct preliminary costing studies to determine which elements to include and assess the potential for cost recovery for various elements of the program.

Activity R2303 – Design and implement the model project using a participatory approach.

R2303.1 – Develop a project planning group and process that involves PLWHAs, families affected by HIV, community volunteers, physicians, nurses, social workers, counselors and other key players.

R2303.2 – Develop training materials and hold training workshops to strengthen the skills among professional staff and community members who will become the training resource for family members and community volunteers.

R2303.3 – Implement the model under the supervision and support of an advisory committee composed of key stakeholders, including people living with HIV/AIDS.

Activity R2304 – Develop mechanisms for the ongoing evaluation of the model.

R2304.1 – Develop strategies and tools to evaluate patient and family member satisfaction with the services received, changes in patients' perceived quality of life, hospital bed utilization, costs to the client, the family and the project, community attitudes toward the project, uptake of VCT services, and other indicators to be determined during the design phase with stakeholders.

R2304.2 – Periodically summarize and report on the project evaluation to the advisory committee, participants in the program and the community through workshops and community meetings.

Activity R2305 – Document and disseminate lessons learned and project impacts.

R2305.1 – Lessons learned in the implementation of the project will be documented and disseminated through RSACS and its implementing partners after validation of findings at the community level.

R2305.2 – An assessment of the potential for replication and associated costs will be determined, with a view to scaling up this approach to other sites.

Activity R2306 – Provide resources and opportunities for hands-on training for other implementers.

The demonstration project will be used to provide training opportunities for program planners and implementers from across the state. Once the demonstration project is operational these opportunities will be promoted.

R2306.1 – Develop training manuals and materials based on the demonstration project activities.

R2306.2 – Train leaders in the demonstration project to provide hands-on training for personnel from various implementing agencies.

R2306.3 – Provide hands-on training programs within the demonstration project.

9. NATIONAL COMPONENT

9.1 SITUATION AND NEEDS ASSESSMENT

At the national level there are two national level organizations or bodies with which are of central importance to HIV/AIDS control in India. These are the National AIDS Control Organization (NACO) and the Technical Resource Groups (TRGs).

9.1.1 National AIDS Control Organization

NACO, situated within the Ministry of Health and Family Welfare, is the main agency responsible for providing leadership to HIV prevention and control efforts in India, as well as efforts to mitigate the impact of AIDS. On December 15, 1999, the Government of India launched NACP-II, funded in large part through a credit from the World Bank, International Development Agency. This five-year program represents India's main effort to combat the HIV/AIDS epidemic. Th program is being supported by the Government of India, the Department for International Development (UK), USAID, AUSAID and most recently the Canadian International Development Agency. The strategic focus of NACP-II is to implement interventions to prevent the spread of HIV that have been shown to be both effective and cost-effective. As a result of some of the implementation problems encountered during NACP-I, and the size and diversity of India, responsibility for program planning and implementation has been devolved to the state level, where implementation of interventions will occur primarily through NGOs and CBOs. The responsibilities of NACO under NACP-II are to set strategic directions for state level AIDS programming, provide financing, offer technical support to state AIDS programs, document the impact of interventions, identify best practices and conduct annual sentinel HIV surveillance. It is also responsible for acquiring commodities important in HIV/AIDS prevention and control, such as condoms, and drugs for the treatment of opportunistic infections and STI. In addition to being supported by the Government of India and bilateral donor agencies, NACO has commitments of substantial technical and financial support from UNAIDS, other UN agencies such as the World Health Organization and several bilateral donor agencies. NACO has considerable political support and has highly capable and effective leadership and senior personnel. However, the capacity of NACO is quite thinly stretched when it is considered that it has to serve India's nearly one billion population.

Through its work in the planning of NACP-II and through the design mission for the current project, the CEA has developed a relationship of mutual respect and trust with NACO. In the implementation of the current project, the CEA will maintain and solidify that relationship. This will be achieved by assisting in the development of excellent state AIDS control programs in Karnataka and Rajasthan, the development and documentation of new best practices in its demonstration projects and through capacity building at NACO.

9.1.2 Technical Resource Groups

As indicated previously, NACP-II is designed to implement highly effective, evidence-based interventions to rapidly reduce HIV transmission. The strategies for interrupting transmission are of necessity community-based or community-oriented and must involve the targeted population at all stages. These approaches cannot be implemented nationally or even at the state

level, but must involve institutions or groups with reach into communities. These implementing organizations may be within local government or may be NGOs or other community-based organizations (CBOs). To effect this strategy, and to overcome some of the problems with implementation of NACP-I, NACO has adopted a decentralized plan for implementation, with funds flowing to para-governmental State or Municipal Corporation AIDS Societies, which in turn contract local agencies for implementation. This decentralization means that different levels of the system (states, municipal corporations, districts, NGOs and CBOs) will need the technical capacity to effectively mount interventions. It is widely recognized that there is a wealth of technical expertise and practical experience in India outside of government (in NGOs, academic departments, in the private sector and elsewhere), which can be brought to bear on the problem of HIV/AIDS control. However, this expertise is scattered, inadequate for the size of the need and in some areas incomplete. To mobilize and strengthen this expertise, NACO and its partners have devised a network of Technical Resource Groups (TRGs) based in key Indian institutions. The plan is that the TRGs will become technical resources for the state, municipal, district and NGO/CBO program implementers, for NACO and for each other.

Twelve TRGs have been constituted and 11 have been convened, their TORs developed, and the chair of each TRG appointed. The individual members of TRGs were chosen by NACO in March/April 1998, and in April 1998, each TRG was provided with start-up resources. From December 1998 each TRG has had a chair, a secretariat (the institution to which the chair belongs), finance, terms of reference, members, and they are now completing their initial best practice documents. In addition, UNAIDS has committed significant financial resources for TRG operations for a two-year period (approximately US $2 million total) and is separately providing the hardware and software for electronic linking of TRGs. Although NACO had envisioned a "trust" fund process whereby multilateral and bilateral donors could contribute to the entire TRG network, this has proved unworkable. Currently, if bilateral funding of TRGs is required, it would flow directly to particular TRGs through NACO. The terms of reference for TRGs are as follows:

- Review the relevant portion of the strategic plan in the current phase of the GOI program and prepare a technical paper describing the state-of-the-art in the identified area under THE HIV/AIDS Prevention and Control Program;
- Identify best practices through systematic evaluation of the present program. The assessment should identify past successes and articulate the elements and context of these successes.
- Determine realistic and achievable program goals in their particular technical area over a period of time. Identify the outcomes and end points for each goal, and both the technical and human resources which may be required to achieve these goals.
- Determine the specific steps that a state would need to take to achieve each set of goals under the identified areas;
- Develop a strategy for interaction with states and union territories in the identified area as a technical resource.

- Develop mechanisms for transfer of technical knowledge to all states and union territories in the relevant field.
- Convene members of the TRG as frequently as required.

While the TRGs have been established, the TRG concept is one in evolution and development, and considerable effort is needed to operationalize the TRGs as technical resources for states, implementers and NACO. Not all TRGs will ultimately have the same functions, and some will have functions that are central to the success of state level implementation, while others will have a more removed policy level role.

There is some concern at the state level as to how the TRGs were constituted. State AIDS society officers feel that they have expertise as well and that there is other expertise in their states that is not being utilized in the TRGs. Thus, the TRGs are to successfully go forward, there must be greater participation by the states in the TRG process and there must be a flow of information on best practices at the state level to the TRGs for analysis and dissemination. Cross-representation of TRGs is also needed, so that those involved in particular technical areas are cognizant of needs in other areas. From a functional perspective, it might also be useful to have terms on TRG membership or conditions for maintaining membership, so that inactive or ineffective TRG members can be removed gracefully.

From the project's perspective, TRGs would ideally have the following functions:

- Critical analysis and evaluation of key interventions.
- Ongoing documentation and dissemination of best practices in India and globally.
- Serving as a resource center for the states and NACO.
- Acting as the centre of a network of centres of special expertise in specific technical areas (linking with states and NGOs with special expertise).
- Advising NACO on policy areas of their competence and providing technical assistance to NACO.
- Advising other TRGs in areas of their competence.
- Providing technical assistance to state program implementers.
- Serving as a mechanism for international organizations (donors and potential donors) to better understand HIV/AIDS programming and to link up with groups in India with similar interests.

As noted above, UNAIDS has taken the lead with many areas of assistance to the TRGs. The project will participate in TRGs through state participation in TRGs and will also remain responsive to potential needs within the TRGs that it can help to meet. In working with NACO, the leadership of selected TRGs and UNAIDS, we will revisit TRG structure, operation and function to determine how the project can contribute to their development and have maximal impact.

9.2 NATIONAL COMPONENT PROJECT DESCRIPTION

9.2.1 Overview

When CIDA initially committed to make a contribution to the Government of India's NACP-II, a substantial involvement at the national level, particularly with the nascent Technical Resource Groups, was envisioned. There was also interest in providing support to NACO's surveillance, and monitoring and evaluation activities. Many of these needs are now being met adequately with support from UNAIDS and other UN agencies such as the World Health Organization. Thus, during the design mission, it was agreed that the project should focus on implementing excellent and innovative HIV/AIDS programming that would inform the national level through the development of innovations and best practices at state and local level, rigorously demonstrating their effectiveness and cost-effectiveness. Similarly, it was felt that the best way that the project could contribute to the development and strengthening of the TRGs was from within, as active members working at the state level.

At the same time, the project has access to a body of world-class expertise in HIV/AIDS programming that can be of benefit to NACO and the TRGs. Thus the project will focus some of its energy and resources to strengthen the capacity of NACO and the TRGs to access and utilize results from effective international and Indian interventions.

This area of activity will consist of one component: capacity building for NACO and selected TRGs.

The expected outputs are the incorporation of international experience and expertise into national HIV/AIDS policy and programming by TRGs and NACO, and the incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming.

9.2.2 Work Breakdown Structure

There are two main outputs for this single WBS component, each with associated activity streams. These are summarized in the figure below. The detailed activities under each of the streams are describe in the following sections.

Component N1000 – Capacity Building for NACO and selected TRGs

- **Output N1100** – Incorporation of international experience and expertise into national HIV/AIDS policy and programming by TRGs and NACO.

- **Output N1200** – Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming by TRGs and NACO.

Component N1000 Capacity Building for NACO and Selected TRGs	
N1100 Incorporation of international experience and expertise into national HIV/AIDS policy and programming by TRGs and NACO	**N1200** Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming by TRGs and NACO
N1101 Documentation of best practices from India and elsewhere **N1102** Increase the utilization of international best practices in India by NACO and TRGs **N1103** Conduct directed research to inform decision-making in selected areas with NACO and TRGs **N1104** Increase the use of evidence-based advocacy and policy formulation by NACO and TRGs	**N1201** Quantify impacts and costs of HIV/AIDS interventions in Rajasthan and Karnataka **N1202** Disseminate innovations and best practices to other state and local programs **N1203** Disseminate innovations and best practices nationally and internationally

9.2.3 Description of Outputs and Activities

Component N1000 – Capacity Building for NACO and selected TRGs

The following strategies will be used as required to enhance capacity at NACO and the TRGs.

Technical Assistance/Mentoring: A network of Canadian and international technical specialists will provide direct technical advice, consultation and mentoring for members of NACO and the TRGs as required. Local Indian technical expertise will also be engaged to offer the same types of support. The areas where the project is highly competent to assist NACO and the TRGs include sentinel surveillance and other aspects of surveillance, evaluation of interventions, implementing syndromic STD management approaches, implementing targeted HIV prevention interventions among high risk groups, HIV voluntary counseling and testing, cost-effectiveness analysis and modeling of intervention options.

Study Tours and International Linkages: There are many examples of high quality HIV/AIDS prevention, care and support programs both in India and elsewhere. Mechanisms for linking NACO and the TRGs to these programs, such as organization and support for study tours, will be developed to promote the use of national and international best practices.

Selected Research: The results of research are perhaps the most powerful tool of advocacy policy. The project can draw on world-class expertise in several research areas that may be needed by NACO. These include policy analysis, operational research on interventions, evaluation of syndromic management efficacy, impact evaluation of interventions, cost-effectiveness analysis and mathematical modeling of the HIV epidemic, including the impact of various interventions on the epidemic. The project will thus reserve a small portion of its resources for selected research initiatives to be undertaken in partnership with NACO or selected TRGs in a responsive manner.

Outputs and Activities

Output N1100 - Incorporation of international experience and expertise into national HIV/AIDS policy and programming by TRGs and NACO.

Activity N1101 - Documentation of best practices from India and elsewhere.

The first step will be to document current best practices from India and elsewhere. This will be effected through literature, key informant interviews and field trips within India.

Activity N1102 - Increase the utilization of international best practices in India by NACO and TRGs.

There are a wide range of best practices in HIV/AIDS programming from around the world of which India could be better informed. This activity will assist in bringing the knowledge

gained from these best practices into programming at national level in India. Sub-activities to achieve this will include:

N1102.1 – Evaluate the impact of selected interventions from India and identify best practices, with NACO and the TRGs..

N1102.2 – Document, compile and analyze best practice interventions from India and other countries.

N1102.3 – Disseminate best practices through workshops, conferences and publications.

Activity N1103 - Conduct directed research to inform decision making in selected areas with NACO and TRGs.

The project's experience in India and elsewhere to date has shown the power of research to inform and direct policy. In this activity, research on specific topics will be undertake to fulfill specific policy research needs at NACO and the TRGs. The sub-activities will include:

N1103.1 – Identify selected areas for research with NACO and the TRGs.

N1103.2 – Design, conduct and analyze specific research undertakings, with NACO and the TRGs.

N1103.3 – Analyze and report on impact and policy implications to NACO and TRGs.

N1103.4 – Disseminate findings widely in India and internationally through publications, workshops and conferences.

Activity N1104 - Increase the use of evidence-based advocacy and policy formulation by NACO and TRGs.

The use of evidence from research or program evaluation in advocacy or to influence policy formulation is an important acquired skill. The project will work with NACO and the TRGs to develop the necessary skills through the following sub-activities:

N1104.1 – Select specific advocacy areas, within project competency, with NACO and the TRGs.

N1104.2 – Develop specific advocacy and dissemination strategies, materials and timetables for different audiences (multilateral agencies, bilateral agencies, Government of India) using workshops, presentations and field visits.

N1104.3 – Execute advocacy strategies.

N11044 – Assess impact on policy and planning.

Output N1200 - Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming by TRGs and NACO.

Activity N1201 - Quantify impacts and costs of HIV/AIDS interventions in Rajasthan and Karnataka.

A major factor that should be an element of decision-making in HIV/AIDS programming in developing countries is the amount of "effect" a particular intervention is capable of producing for the cost input. This needs to be compared both in terms of effect and cost for effect to other potential interventions. The project will work with NACO and the TRGs to determine the effect of specific interventions and the cost they incur to produce the effect in the following sub-activities:

N1201.1 – Evaluate interventions from project demonstration projects or other implementers to identify innovations and best practices at state level, with RSACS and KSAPS.

N1201.2 – Document, compile and analyze innovations and best practices with RSACS and KSAPS.

N1201.3 – Estimate numbers of HIV infections prevented and the cost of various interventions, and compare cost-effectiveness.

Activity N1202 - Disseminate innovations and best practices to other states and local programs.

N1202.1 – Develop dissemination strategies and materials for different audiences (multilateral agencies, bilateral agencies, Government of India) using publications, workshops, presentations and field visits.

N1202.2 – Execute dissemination plan.

N1202.3 – Assess impact on policy, planning and funding of interventions at state and national levels, and with programming by multilateral and bilateral agencies.

Activity N1203 - Disseminate innovations and best practices nationally and internationally.

In addition to dissemination within India, it is important to disseminate innovations and best practices to a wider national and international audience. This will be effected through publications, workshops and presentations at national and international conferences.

10. MANAGEMENT COMPONENT

Effective project management will ensure that the activities described in the preceding sections of this document will take place in a timely fashion, using an effective and efficient mix of resources, and that the project will be managed to the best of the ability of all project partners in order to achieve the stated project results. According to CIDA's Results-Based Management principles[4], the responsibility for achieving these results are shared between the key project stakeholders, i.e. executing agencies, developing country partners and CIDA. Therefore, the responsibility of overall project management is also shared between these key stakeholders. In the case of this project, key stakeholders are:

- The Government of Canada (GOC), represented by the Canadian International Development Agency (CIDA) and the Canadian High Commission (CHC) in India.
- The Government of India (GOI), represented by the Department of Economic Affairs (DEA) of the Ministry of Finance (MOF) and the Ministry of Health and Family Welfare.
- The National AIDS Control Organization (NACO) of the Ministry of Health and Family Welfare.
- The Karnataka State AIDS Prevention Society (KSAPS) and its implementing partners.
- The Rajasthan State AIDS Control Society (RSACS); and its implementing partners.
- The Canadian Executing Agency (CEA), represented by its management team in Canada and in India.

10.1 WORK BREAKDOWN STRUCTURE

The Work Breakdown Structure (WBS), listing all management activities that have to be carried out by each of the above stakeholders to ensure successful implementation of the project, is presented below and the key activities are described in the following section.

[4] Planning and Reporting for Results (page 7), Strategic Planning and Policy Division, CIDA Asia Branch, March 1999

WORK BREAKDOWN STRUCTURE FOR PROJECT MANAGEMENT

PM1000 CIDA	PM2000 CHC	PM3000 GOI	PM4000 NACO	PM5000 KSAPS	PM6000 RSACS	PM7000 CEA in Canada	PM8000 CEA in India
PM1001 Review and approve PIP		**PM3001** Approve project	**PM4001** Review and Approve PIP	**PM5001** Review and approve PIP	**PM6001** Review and approve PIP	**PM7001** Submit PIP to CIDA & finalize after feedback	
PM1002 Obtain GOC approval of project							
PM1003 Amend CEA contract for Project delivery	**PM2001** Sign MOU with GOI and NACO	**PM3002** Sign MOU with CHC	**PM4002** Sign agreements with CEA, KSAPS and RSACS	**PM5002** Sign agreements with NACO and CEA	**PM6002** Sign agreements with NACO and CEA	**PM7002** Sign agreements with CIDA, NACO, KSAPS and RSACS	
PM1004 Provide initial advance and disburse funds	**PM2002** Facilitate establishment of field office and relocation of resident coordinators		**PM4003** Disburse funds to KSAPS and RSACS on schedule	**PM5003** Facilitate establishment of field office and relocation of resident coordinator	**PM6003** Facilitate establishment of field office and relocation of resident coordinator	**PM7003** Mobilize project personnel, including resident coordinators, and establish field offices	**PM8001** Establish field office, procure office furniture and equipment
				PM5004 Receive funds from [illegible]	**PM6004** Receive funds from [illegible]	**PM7004** Receive funds from [illegible] NACO for project activities	**PM8002** Recruit professional [illegible]
			PM4004 Collect data for internal performance monitoring	**PM5005** Collect data for internal performance monitoring	**PM6005** Collect data for internal performance monitoring	**PM7005** Carry out internal performance monitoring	**PM8003** Collect data for internal performance monitoring
			PM4005 Support Canadian consultants as necessary	**PM5006** Support Canadian consultants as necessary	**PM6006** Support Canadian consultants as necessary	**PM7006** Deploy Canadian consultants as necessary	**PM8004** Support Canadian consultants as necessary
			PM4006 Support preparation of reports and workplans	**PM5007** Support preparation of reports and workplans	**PM6007** Support preparation of reports and workplans	**PM7007** Prepare and submit reports and workplans	**PM8005** Prepare and submit reports and workplans
PM1005 Review and approve reports and workplans on time		**PM3003** Review and approve reports and workplans on time at appropriate committees	**PM4007** Review and approve reports and workplans on time at appropriate committees	**PM5008** Review and approve reports and workplans on time at appropriate committees	**PM6008** Review and approve reports & workplans on time at appropriate committees		
			PM4008 Provide input to the project as necessary in a timely fashion	**PM5009** Provide input to the project as necessary in a timely fashion	**PM6009** Provide inputs to the project as necessary in a timely fashion	**PM7008** Provide overall project management and administration	**PM8006** Provide project management and administration in India
PM1006 Participate in project committees as required	**PM2003** Participate in project committees as required	**PM3004** Participate in project committees as required	**PM4009** Participate in project committees as required	**PM5010** Participate in project committees as required	**PM6010** Participate in project committees as required	**PM7009** Participate in project committees as required	**PM8007** Participate in project committees as required

10.2 DESCRIPTION OF ACTIVITIES AND OUTPUTS

The following activities are described in sequence, as they will occur from the time when the Project Implementation Plan is submitted.

10.2.1 ***Activity PM7001 – Prepare and Submit PIP to CIDA (CEA)***

After completion of the Project Design Mission to India, the CEA will produce the draft PIP and submit it to CIDA. It will then be forwarded to NACO, KSAPS and RSACS for comments. The draft will be submitted in February 2000. As soon as comments are received, the CEA will produce the final PIP and submit it to CIDA.

Output: A Project Implementation Plan (PIP) finalized and completed.

10.2.2 ***Activity PM1001 – Review and Approve PIP (CIDA)***
Activity PM4001 – Review and Approve PIP (NACO)
Activity PM5001 – Review and Approve PIP (KSAPS)
Activity PM6001 – Review and Approve PIP (RSACS)

The draft PIP will be submitted by the CEA to all its partners (CIDA, NACO, KSAPS and RSACS) they will be expected to provide comments. The CEA will incorporate the comments and submit the final PIP to CIDA. CIDA will then distribute the final PIP to all the partners for approval. This approval is expected to take approximately 3 months.

Output: PIP approved by CIDA, NACO, KSAPS and RSACS.

10.2.3 ***Activity PM1002 – Obtain GOC Approval of Project (CIDA)***
Activity PM3001 – Obtain GOI Approval of Project (DEA, GOI)

The project will have to go through the normal approval process in CIDA for GOC, and DEA for GOI.

Output: Project Approved by CIDA (GOC) and DEA (GOI).

10.2.4 ***Activity PM2001 – Sign MOU with GOI (CHC, GOC)***
Activity PM3001 – Sign MOU with CHC (DEA, GOI)

On approval of the project by the governments of both countries, a Memorandum of Understanding (MOU) for implementation of the project will be signed between the two governments.

Output: MOU between GOC and GOI on implementation of the project.

10.2.5 ***Activity PM1003 – Amend CEA's Contract for Project Delivery (CIDA)***
Activity PM7002 – Sign Agreement (Amendment) with CIDA (CEA)

CIDA will amend the CEA's contract to incorporate the activities and resources required to deliver the project. The contract will be amended in accordance with this PIP.

Output: Amended CEA Contract for Project Delivery.

10.2.6 ***Activity PM4002 – Sign Agreement with CEA, KSAPS and RSACS (NACO)***
Activity PM5002 – Sign Agreement with NACO, RSACS and CEA (KSAPS)
Activity PM6002 – Sign Agreement with NACO, KSAPS and CEA (RSACS)
Activity PM7002 – Sign Agreement with NACO, KSAPS and RSACS (CEA)

The finalized PIP will be signed by the CEA and its partners in India.

Output: A four-way agreement between NACO, RSACS, KSAPS and the CEA for implementation of the project.

10.2.7 ***Activity PM1004 – Provide Initial Advance and Disburse Funds to CEA (CIDA)***

CIDA will be responsible for advancing funds to the CEA for initial project mobilization and for procurement of project-related equipment and furniture as required.

Output: Project funds received by the CEA on schedule.

10.2.8 ***Activity PM7003 – Mobilize project personnel including Field Coordinators (CEA)***

Immediately after signing the contract amendment with CIDA, the CEA team will mobilize for project activities. To provide on-going technical assistance and to coordinate project activities jointly with the directors of the state AIDS societies, a full-time Resident Canadian Coordinator (RCC) will be recruited and provided in each state. This activity will be on-going with deployment of short-term Canadian Advisers for technical assistance activities, as necessary.

Output: RCCs recruited and placed in Bangalore and Jaipur.

10.2.9 ***Activity PM8001 – Establish and operate field office (CEA).***

The RCCs will establish the field offices and arrange for office space rental and procurement of furniture and equipment in India.

Output: CEA Field offices established in Bangalore and Jaipur.

10.2.10 ***Activity PM2002 – Facilitate establishment of field office and relocation of field coordinator (CHC)***

The CHC in New Delhi will facilitate obtaining work permits for the CEA's Resident Canadian Coordinators. The CHC will also assist the CEA in obtaining duty-free privileges for project-related shipments.

Output: CEA RCCs placed and field offices established in Bangalore and Jaipur.

10.2.11 ***Activity PM5003 – Facilitate establishment of field office and relocation of RCC (KSAPS)***
Activity PM6003 – Facilitate establishment of field office and relocation of RCC (RSACS)

KSAPS and RSACS will facilitate the establishment of the field offices and relocation of RCCs by securing any government approvals, if required, such as acceptance of CVs of the individuals, obtaining work permits, permits to set up offices in India etc. They will also assist the CEA to procure furniture and equipment for the project, to get any project-related shipments released from customs, securing duty free privileges, etc.

Output: RCCs placed and field offices established in Bangalore and Jaipur.

10.2.12 ***Activity PM4003 – Disburse funds to KSAPS and RSACS on schedule (NACO)***

NACO will be responsible for the timely disbursement of funds to KSAPS and RSACS for project activities. NACO will ensure that this flow of funds is not interrupted to an extent that project activities suffer.

Output: Funds received by KSAPS and RSACS on time.

10.3.13 ***Activity PM5004 – Receive and disburse funds from NACO on schedule (KSAPS)***
Activity PM6004 – Receive and disburse funds from NACO on schedule (RSACS)

KSAPS and RSACS will be responsible for timely disbursement of funds to project activities. They will ensure that this flow of funds does not get interrupted to an extent that project activities suffer.

Output: Funds disbursed by KSAPS and RSACS on time.

10.2.14 ***Activity PM7004 – Receive funds from CIDA and disburse for project management and to NACO for project activities (CEA)***

According to the contract between the CEA and CIDA, the CEA will receive funds from CIDA on a reimbursement basis, other than mobilization costs (relocation expenses, office establishment costs, etc.). The CEA will also have an agreement

with NACO to the effect that for predetermined project activities, the CEA will reimburse funds to NACO when NACO has spent the funds.

Output: Efficiently managed project activities.

10.2.15 ***Activity PM8002 – Recruit professional and support staff (CEA)***

To provide technical assistance on project activities in each state, the RCC will be supported by a pool of technical specialists from Canada and India, and a project support unit. The pool of Indian specialists will be contracted as required on a full-time or part-time basis. The expertise of the RCCs and the technical specialists in each state will be complementary to their counterparts in the other state, to ensure that as wide a range as possible of technical expertise is available to support activities. Support staff will be recruited locally as well. Support staff may include an accountant, a secretary, drivers and other staff. The professional staff may include specialists in training, STD, HIV-related care and support, communications, research, targeted interventions etc. All staff will recruited in consultation with KSAPS and RSACS.

Output: Fully staffed field project offices in Bangalore and Jaipur.

10.2.16 ***Activity PM7005 – Carry out Internal Performance Monitoring (CEA)***

To ensure achievement of results throughout the project, the CEA will establish an internal performance monitoring system on the basis of which project reports will be prepared and submitted to CIDA. The CEA will appoint an Internal Monitoring Coordinator (IMC). Once the specific project activities are designed, the performance measurement framework for project components will be finalized with the participation of other stakeholders. Data on these indicators of performance will be collected on a regular basis and will be reviewed twice a year by the IMC. Regular reports will be prepared for submission to CIDA.

Output: PMF established and project activities and results monitored.

10.2.17 ***Activity PM4004 – Collect data for internal performance monitoring (NACO)***
Activity PM5005 – Collect Data for Internal Performance Monitoring (KSAPS)
Activity PM6005 – Collect data for internal performance monitoring (RSACS)
Activity PM8003 – collect data for internal performance monitoring (CEA)

The performance monitoring data on the indicators will be collected according to the PMF for each project component by NACO, KSAPS and RSACS. The CEA will assist and advise in this data collection.

Output: Data on Performance Indicators.

10.2.18 ***Activity PM7006 – Deploy Canadian consultants as necessary (CEA)***

To provide technical assistance on project activities in each state, the RCCs will be supported by a pool of technical specialists from Canada, as necessary. Timely deployment of these Canadian specialists is essential for the success of the project.

Output: Canadian consultants deployed as required.

10.2.19 ***Activity PM4005 – Support Canadian consultants as necessary (NACO)***
Activity PM5006 – Support Canadian consultants as necessary (KSAPS)
Activity PM6006 – Support Canadian consultants as necessary (RSACS)
Activity PM8004 – Support Canadian consultants as necessary (CEA)

NACO, KSAPS and RSACS will provide support to Canadian and other external consultants, as will the Technical Support Units and the RCCs in India.

Output: Canadian consultants successfully carry out their assignments in India.

10.2.20 ***Activity PM7007 – Prepare and submit reports and workplans (CEA in Canada)***
Activity PM8005 – Prepare and submit reports and workplans (CEA in India)

Semi-annual and annual progress reports will be prepared by the CEA and submitted to CIDA. Annual workplans will also be prepared by the CEA and its implementing partners and submitted to the Project Steering Committee for approval.

Outputs: Periodic Reports and Annual Workplans.

10.2.21 ***Activity PM4006 – Support the preparation of reports and workplans (NACO)***
Activity PM5007 – Support the preparation of reports and workplans (KSAPS)
Activity PM6007 – Support the preparation of reports and workplans (RSACS)

The implementation teams of NACO, KSAPS and RSACS will support the CEA on the preparation of reports and workplans in the field.

Outputs: Periodic Reports and Annual Workplans

10.2.22 ***Activity PM1005 – Review and approve reports and workplans (CIDA)***

CIDA will approve the semi-annual and annual reports and workplans within four weeks of submission.

Outputs: Approved reports and workplans.

10.2.23 *Activity PM4007 – Review and approve workplans (NACO)*
Activity PM5008 – Review and approve workplans (KSAPS)
Activity PM6008 – Review and approve workplans (RSACS)

The project workplans have to be approved by the appropriate committees at the national (NACO) and the state (KSAPS/RSACS) levels.

Outputs: Approved workplans in India.

10.2.24 *Activity PM4008 – Provide inputs to the project as necessary (NACO)*
Activity PM5009 – Provide inputs to the project as necessary (KSAPS)
Activity PM6009 – Provide inputs to the project as necessary (RSACS)

As stipulated by the workplan, timely inputs from the national and state level partners are necessary for the success of the project.

Output: Efficient and effective completion of project activities.

10.2.25 *Activity PM8006 - Provide project management in India (CEA in India)*

This activity will entail all project management and administrative activities in India including financial management, management of staff and assets of the project field offices in Bangalore and Jaipur., liaison with government agencies at the national and state levels, and with others as necessary.

Output: Effectively and efficiently managed project activities in India.

10.2.26 *Activity PM7008 - Provide overall project management (CEA in Canada)*

This activity will include all project management and administrative activities in India and in Canada, including financial management, management of human resources, liaison with CIDA, and with others as necessary.

Output: Effectively and efficiently managed project.

10.2.27 *Activity PM1006 – Participate in Project Steering Committee (CIDA)*
Activity PM2003 – Participate in Project Steering Committee (CHC)
Activity PM3004 – Participate in Project Steering Committee (GOI)
Activity PM4009 – Participate in Project Steering Committee (NACO)
Activity PM5010 – Participate in Project Steering Committee (KSAPS)
Activity PM6010 – Participate in Project Steering Committee (RSACS)
Activity PM7009 – Participate in Project Steering Committee (CEA in Canada)
Activity PM8007 – Participate in Project Steering Committee (CEA in India)

All of the key stakeholders will participate in the Project Steering Committee and thus in the project's policy decision-making.

Output: Well Directed Project.

11. STRATEGY FOR RESULTS-BASED MANAGEMENT

11.1 RBM AND PERFORMANCE MONITORING APPROACH

The India-Canada Collaborative HIV/AIDS Project is innovative and iterative in nature. The project will be implemented using results-based management (RBM) principles. On-going performance assessment will be necessary to ensure effective project management and implementation. In keeping with RBM principles, the project will carry out on-going performance monitoring by establishing and using an effective Performance Measurement System (PMS). The PMS will include the use of the following tools:

- Logical Framework Analysis (LFA).
- Performance Measurement Framework (PMF).
- Risk Management Framework (RMF).
- Management Information System (MIS).
- Key Success Factors.

All of these tools either have been developed with or will incorporate ideas from the Design Mission, but at the present time they should be viewed as provisional, to be further developed with the full participation of project partners and stakeholders in India. An important feature of RBM is that ongoing adjustments are made to revise and adapt project activities to stay focused on results that the project has set out to achieve within a project context which is dynamic.

Based on the established PMF and RMF, a framework for a baseline evaluation will be created. This will include the indicators for which data will be collected. Preliminary data for testing the method of collection and the suitability of the indicators will first be gathered. All data will be disaggregated by gender. Before each major activity begins, data on the performance indicators for achievement of results by the activity as well as data on risk indicators will be collected and the conditions recorded and/or documented. Mechanisms will be established to track both quantitative and qualitative aspects of the project's performance with respect to attainment of target performance indicators at the activity/output, outcome and impact levels. According to the frequency established in the PMF and RMF, data will be collected and analyzed on a regular basis. Monitoring at the output level will be more frequent than at the outcome level. Monitoring at impact level may be at mid-project and on project completion. Milestones will be established for review of result achievement so that the project design can be reassessed for achievement of desired results. A reporting framework during project implementation will also be established.

The PMF and the RMF will be used as the basis for internal monitoring. The annual report will contain the data collected on the performance indicators and the performance of the project towards achievement of the intended results will be reviewed, analyzed and conclusions presented. This information will be used to guide the annual strategic planning process which will result in changes in the project design or performance indicators, as necessary, to achieve the desired results.

11.2 ORGANIZATIONAL STRATEGY

For effective and efficient operation of the PMS within the project, the CEA has created a position of Internal Monitoring Coordinator. The IMC will be responsible for:

- Facilitating the participatory process for the establishment of results, indicators and the performance measurement framework.
- Facilitating the establishment of the logical framework analysis.
- Facilitating the identification of risks and establishment of the risk management strategy.
- Facilitating the establishment of the management information system based on the data on indicators for performance and risks.
- Supervising the ongoing collection and analysis of data on indicators and risks and utilizing them for results-based management of the project.
- Periodic reporting on results and recommending changes in indicators and collection methods as necessary.

11.3 INTEGRATION OF STAKEHOLDER PARTICIPATION

RBM and participatory development approaches are complementary. To successfully achieve results, projects must be designed and implemented using a participatory approach where all stakeholders are involved throughout the project cycle. Expected results and their performance indicators must be mutually defined and agreed upon through a consensus-building process involving all major stakeholders. They should be involved in the establishment of the Performance Measurement Framework and the Risk Management Framework for the project. This RBM approach was used throughout the design mission. In both states, the state AIDS societies participated fully in designing their project components. In addition to ongoing consultations during field trips and meetings with local institutions and NGOs, three workshops were held, one at each state and one at the national level. Due to time constraints, the PMF and the RMF could not be completed in the field, and it is therefore proposed that the draft documents developed the Design Team be further refined through a participatory process in the field at the outset of project implementation.

During the implementation phase and throughout the project, stakeholders (such as the state AIDS societies and NGOs involved in project activities) will participate in the process of reviewing and refining outcomes, outputs and indicators for various components of the project. Experience indicates that projects are better able to adapt to local conditions, leverage resources, and enhance program impact through processes that enable stakeholders to meet and articulate expected results and indicators. There is also a good deal of evidence that better results are achieved through a once-a-year strategic planning process (workshop) involving all stakeholders. It is therefore proposed that such strategic planning workshops be held on an annual basis.

11.4 LOGICAL FRAMEWORK ANALYSIS

At the final workshop of the Design Mission, the stakeholders were presented with the conceptual outcomes, outputs and activities of the project components. The discussions during that workshop and the workshops held at the state level in Rajasthan and Karnataka provided

inputs to the development of the LFA which is included in this report in Section 6. Because of the iterative nature of the project, this LFA should be viewed as a dynamic document, to be revised as the Performance Measurement Framework is revised.

11.5 Performance Measurement Framework

For purposes of monitoring and reporting to CIDA and other partners, the main tool will be the Performance Measurement Framework (PMF). The PMF not only identifies the performance indicators for achievement of each result, it also provides information on the method and frequency of collecting data on each indicator and the assumptions and risks associated with the realization of each result. The effectiveness of this RBM tool depends on the extent to which it incorporates the full range of stakeholder views. As mentioned above, due to shortage of time during the Design Mission, the PMF could not be completed in India with participation of all the stakeholders. Therefore, at this stage, a preliminary PMF has been developed and is available, but is not included in the Project Implementation Plan at this stage. The PMF will be completed with the participation of all stakeholders in India at the outset of when the detailed activities will be designed.

11.6 Risk Management Framework

Based on the assumptions and risks identified in the PMF, a risk analysis will be conducted and a Risk Management Framework (RMF) established. For each assumption, the RMF identifies risk indicators, i.e. data which will be collected on a regular basis to provide advance warning that an assumption may not be not holding true. Activities may then be redirected to avoid any adverse results. As with the PMF, the RMF will also provides information on the method, source and frequency of collecting data on each risk indicator. Stakeholder participation is essential in identifying assumptions, assessing risks and establishing risk indicators. An RMF format has been developed and is available, but like the draft PMF, has not been included in the Project Implementation Plan at this stage.

12. PROJECT MANAGEMENT DETAILS

12.1 PROJECT MANAGEMENT STRATEGY

As per results-based management principles, the CEA, jointly with its Indian partners, will be responsible for ensuring that the conditions are met to produce the project outcomes, thereby achieving the project purpose. The Indian partners are the National AIDS Control Organization at the national level, and the Karnataka State AIDS Prevention Society and the Rajasthan State AIDS Control Society (RSACS). The project has been designed by the CEA in collaboration with the Indian partners and will be implemented jointly.

In keeping with the project's underlying philosophy of capacity building for the state AIDS societies, an organizational structure for project implementation has been developed which represents integration of the CEA inputs with that of the two societies. This is depicted in the Project Organization Chart below.

In Canada, the Project Director from the University of Manitoba will be accountable to CIDA, on behalf of the CEA, for overall project management, as well as the efficient and effective use of CIDA's inputs to the project. To provide on-going technical assistance and to coordinate project activities jointly with the directors of the state AIDS societies, a full-time Resident Canadian Coordinator (RCC) will be deployed in each state. In addition to her/his responsibility to coordinate CEA input and activities in the state, the RCA will be available to the society director and her/his team for technical assistance and support. To integrate the project within the state systems, each RCC will participate in state AIDS society meetings. The RCCs and the society directors will have authority to jointly manage activities funded wholly or partly by CIDA. Integration of the RCCs into the societies' activities will not only obviate the need for a Project Management Committee, but will strengthen the spirit of working together within the existing system, rather than establishing a parallel system for the CIDA-funded activities only. In addition, the RCCs will communicate regularly with the Canadian High Commission in New Delhi, on technical, financial and administrative issues.

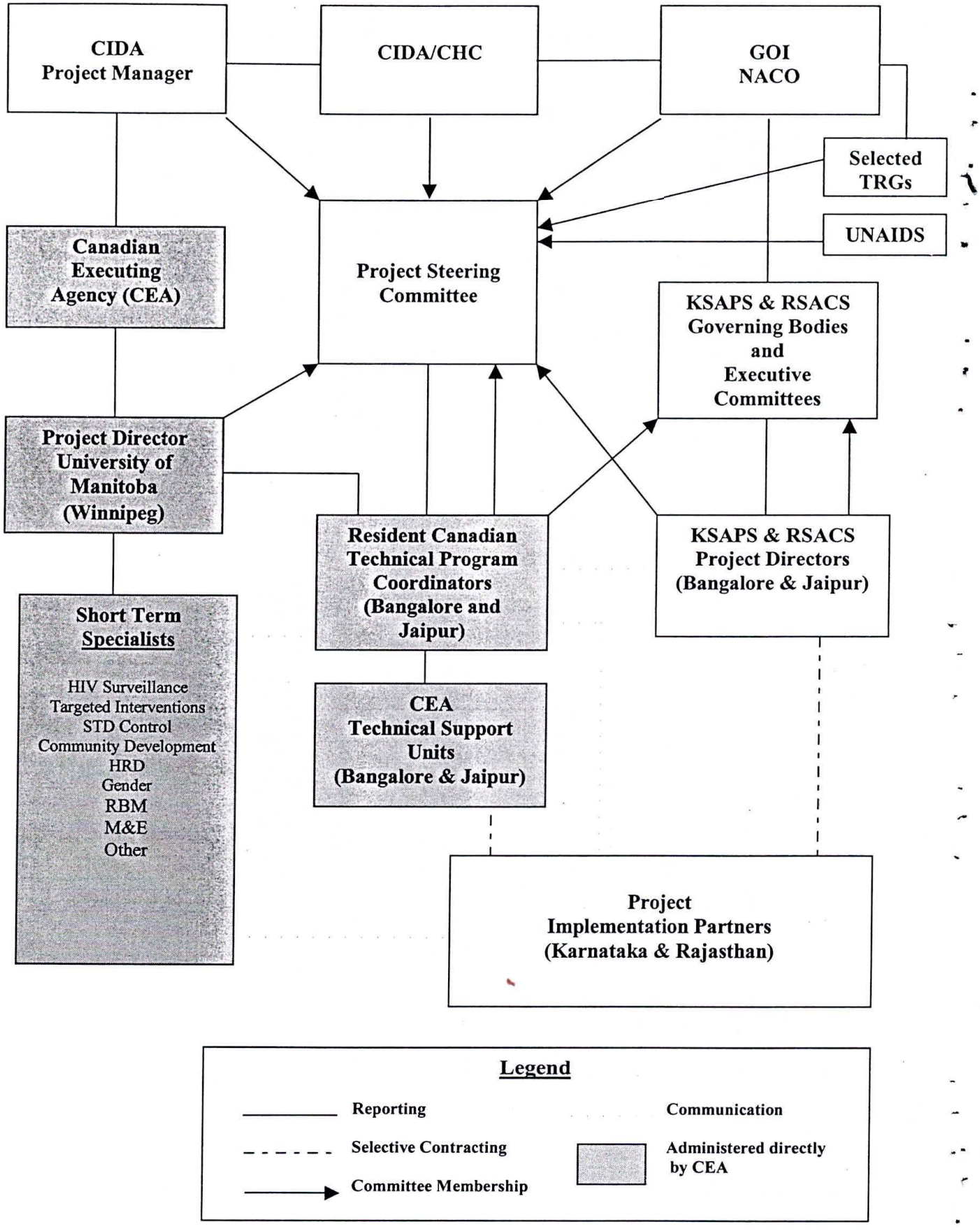
At the overall project level, a Project Steering Committee (PSC) will make policy decisions and review annual workplans for project activities in both states and at the national level. The membership of the PSC will include representatives from NACO, the directors of the two state AIDS societies, the RCCs from the two states, representatives of CIDA and the Canadian High Commission in India, the CEA's Project Director from Canada and other partners. NACO will convey important PSC decisions to the governing bodies of the state societies through its regular channels of communication.

To provide technical assistance on project activities in each state, each RCC will be supported by a pool of technical specialists from Canada and India, and a technical support unit. The pool of Indian specialists will be contracted as required on a full-time or part-time basis. The expertise of the RCCs and the technical specialists in each state will be complementary to their counterparts in the other state, to ensure that as wide a range as possible of technical expertise is available to support activities.

12.2 PROJECT ORGANIZATION CHART

The Project Organization Chart is graphically depicted on the following page, as per the relationships described above.

PROJECT ORGANIZATION CHART



12.3 PROJECT STAFFING

The Canadian Executing Agency (CEA) is led by the University of Manitoba, with Mascen Consultants Inc. and ProAction: Partners for Community Health as partners. The University of Manitoba has been contracted by CIDA and will provide the following short and long-term professional consultants to carry out the India-Canada Collaborative HIV/AIDS Project.

Canada-Based Project Staff

- Project Director
- Internal Monitoring Coordinator
- Administrative Support

Long-Term Canadian Coordinators

- Resident Canadian Coordinator – Karnataka
- Resident Canadian Coordinator – Rajasthan

In order to meet the requirements as outlined in the Work Breakdown Structures of the various project components, the project will require substantial inputs of technical assistance. The CEA has already identified part of the Canadian technical assistance team in its proposal which has been accepted by CIDA. Additional Canadian and Indian resources may be recruited as required. The following areas are the ones which been identified during the project design as requiring Canadian, international or Indian technical assistance.

- HIV surveillance systems
- targeted interventions
- STI Control for HIV prevention
- community health and development
- training
- human resource development
- gender and development
- results – based management
- research and evaluation
- communications
- HIV-related care and support

12.4 PROJECT OFFICES

As mentioned earlier in this document, a project office will be established in each project state. To ensure close liaison and to establish close working relationships between the two project partners (the CEA and the State AIDS Control/Prevention Society), one of the major criteria for location will be close proximity to, if not in the same location as, the state society. For project administration, the project office in each state will have an Office/Finance Manager and a Secretary/Logistics Coordinator. The office will also house the Technical Support Unit of the project and that will require working space for a maximum of five professionals.

12.5 FINANCIAL MANAGEMENT

The CEA will open a project account in each of the two states in India. Funds will be transferred to this account by the CEA from Canada for project purposes, as approved by CIDA and the Project Steering Committee through the annual workplan. Records of all project-related expenditures will be kept up-to-date in the project office. Financial management guidelines will be established by the RCC and the Office/Financial Manager. A University of Manitoba accountant and the Canada-based Project Director in Winnipeg will review all financial reports submitted by the project office and prepare semi-annual financial reports for submission to CIDA. The CEA will submit invoices to CIDA on a monthly basis. Requests for advances will be submitted as needed. The project's financial records will be subject to a financial audit if CIDA requests one.

The CEA will receive funds from CIDA on a reimbursement basis, except for allowed advances, and will be accountable to CIDA for all expenditures. Expenditure of funds will be governed by annual and quarterly project workplans approved by the Project Steering Committee, with agreement by CIDA, the CEA, NACO and state AIDS societies.

Funds for CEA management costs and technical assistance, including the RCCs and associated technical support units, will be administered by the CEA. Funds for activities at state or national level will be managed by NACO on a reimbursement basis, as per Department of Economic Affairs (DEA) guidelines. NACO will provide funds for activities to the two state AIDS societies on an annual or quarterly basis, as per the approved annual and quarterly workplans, and will be reimbursed by the CEA upon presentation of accounts of expenditures. To facilitate timely disbursement and accounting, a financial officer position will be budgeted for the project at NACO level and at each of the two state levels.

12.6 ROLES AND RESPONSIBILITIES

12.6.1 Government of India

The Government of India (GOI), through its Department of Economic Affairs (DEA) of the Ministry of Finance, will have the following responsibilities:

- Obtain all necessary project approval.
- Negotiate and sign a Memorandum of Understanding (MOU) with the Government of Canada (represented by the Canadian High Commissioner in India) for implementation of the project.
- Provide and obtain from the appropriate GOI department all necessary approvals and documentation to facilitate ease of entry to and exit from India of Canadian personnel assigned to the project on long-term or short-term basis, their personal effects as well as equipment and material required for the project.
- Arrange approvals for all work permits necessary and duty-free exemptions and privileges for Canadian project personnel resident in India.
- Nominate NACO to be the Indian agency responsible for project implementation.

12.6.2 Government of Canada (CHC, New Delhi)

The Canadian High Commission in New Delhi will represent the Government of Canada on project-related issues at government to government level, will represent CIDA on all project related matters in India and will be responsible for on-going liaison with the GOI and NACO. Without limiting the generality of the above, the CHC will be responsible for the following:

- Negotiating and signing the Memorandum of Understanding with the DEA.
- Liaising with NACO on project-related matters.
- Liaising with the CEA through its representatives in India on project matters.
- Keeping CIDA headquarters informed and up-to-date on any significant activities or problems which may affect the successful implementation of the project.
- Participating in Project Steering Committee meetings.

12.6.3 Government of Canada (CIDA)

The overall responsibility of managing the Government of Canada's inputs rests with CIDA's headquarters in Hull, with Project Team led by a Project Manager. The Project Team's responsibilities include:

- Approving the Project Implementation Plan and obtaining all necessary GOC approvals for project funding.
- Preparing the Memorandum of Understanding (MOU) for signing with the DEA, GOI.
- Amending CEA's contract to include implementation activities as per to this PIP.
- Monitoring project activities, and reviewing and commenting on progress and financial reports.
- Timely disbursement of Project funds.
- Participation in the Project Steering Committee.

12.6.4 National AIDS Control Organization of India (NACO)

NACO, along with the state AIDS societies of Karnataka and Rajasthan, will be responsible for the achievement of the project purpose. In particular, its responsibilities will include:

- Obtaining the necessary project approvals from the appropriate GOI authority and ensuring that project funding is approved and allocated.
- Signing the necessary implementation agreement with the CEA.
- Providing KSAPS and RSACS with sufficient funds to implement project activities. These funds will consist of project funds derived from CIDA through the CEA, and other program funds supplied by NACO which will complement project funds. The mix of funding modalities will be specified for specific project activities in the annual workplans.
- Facilitating and expediting project activities in case of any problem at the national or state level.

- Participating in the design and implementation of project activities.
- Collecting and analyzing data for on-going performance measurement of the project as stipulated in the performance measurement framework.
- Coordinating and chairing the Project Steering Committee;

12.6.5 State AIDS Societies

The state AIDS societies of Karnataka and Rajasthan (KSAPS and RSACS), along with NACO, will be responsible for the achievement of the project purpose. In particular, their responsibilities will include:

- Obtaining the necessary project approvals from the appropriate state authorities and ensuring that the project funding is approved and allocated.
- Signing the necessary implementation agreement with the CEA.
- Allocating sufficient funds to implement project activities. These funds will consist of project funds derived from CIDA through the CEA and NACO, and other program funds which will complement project funds. The mix of funding modalities will be specified for specific project activities in the annual workplans.
- Facilitating project activities in the event of any problems at the national or state level.
- With the RCC and other project personnel, carrying out the detailed project implementation.
- Providing sufficient and appropriate human and financial resources to the project.
- Collecting and analyzing data for on-going performance measurement of the project as stipulated in the performance measurement framework.
- Nominating the Project Director to be the counterpart of the RCC and to sit on the Project Steering Committee.

12.6.6 Canadian Executing Agency

Once the PIP is accepted by CIDA and the project approved by CIDA, a contract amendment will be signed between CIDA and the University of Manitoba for the implementation of the approved project.

During project implementation, the CEA will be responsible for the following activities:

- Providing project management services.
- Within the first six months of the project, preparing a detailed Inception Report to include updated procedures, activity packages, schedules and budgets.
- Regular internal performance measurement and reporting to CIDA.
- Taking remedial actions to correct deviations and resolve problems.
- Providing the technical assistance required by the project by using Canadian, international and Indian technical specialists.

- Providing two full-time Canadian coordinators to be resident in India, one in Bangalore and one in Jaipur (the Resident Canadian Coordinators).
- Establishing a Project Office in each state.
- Staffing the offices and technical support units with the necessary human resources.
- Administering the provision of all Canadian inputs.
- Preparing and submitting project reports on schedule.
- Procuring all CIDA-funded equipment and material in accordance with CIDA guidelines on procurement.
- Cooperating with and providing support to any project monitoring, evaluation or other missions arranged by CIDA.
- Providing general administrative and support services to the project in Canada and India.

12.6.7 Project Steering Committee (PSC)

The Project Steering Committee (PSC) will be the key policy body for the project and will be responsible for providing overall project coordination and decisions on policy issues.

The membership of the PSC will be as follows:

NACO:	Director (Chair)
KSAPS:	Project Director
RSACS:	Project Director
CIDA :	Representative based at the Canadian High Commission in New Delhi
	Representative based at CIDA headquarters in Canada
CEA:	Project Director (Canada)
	Resident Canadian Coordinator – Karnataka (Alternate Secretary)
	Resident Canadian Coordinator – Rajasthan (Alternate Secretary)
Ex Officio:	Selected TRG representatives
	UNAIDS representative

The committee will meet at least once a year in India and may meet more frequently, if required. The CEA will be the Secretariat for the Committee. The two RCCs will alternatively act as the Secretary for the committee. The PSC will:

- Provide policy guidelines and direction.
- Review and approve workplans and budgets.
- Make adjustments to project targets, if necessary, on the basis of field experience and periodic review.
- Discuss and act upon any implementation problems.

The decisions taken by the PSC with respect to activities in the states will be conveyed by NACO to the state societies for appropriate action.

13. PROPOSED BUDGET

13.1 BUDGET BY COMPONENT

The budget by component is presented in the Table below. Budget notes follow. All figures are in constant Canadian dollars (CAD).

Item	Component	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.0	Management in Canada	167,000	167,000	167,000	167,000	167,000	835,000
2.0	Management and Operations in India	165,000	165,000	165,000	165,000	165,000	825,000
3.0	Procurement	247,000		77,000			324,000
4.0	Technical Assistance and Support	896,100	942,900	942,900	942,900	942,900	4,667,700
5.0	Karnataka Programming						
5.1	Component K1000 – Capacity Building	34,000	43,500	43,500	43,500	43,500	208,000
5.2	Component K2000 – Demonstration project	402,500	501,000	501,000	501,000	501,000	2,406,500
	Sub-Total	436,500	544,500	544,500	544,500	544,500	2,614,500
6.0	Rajasthan Programming						
6.1	Component K1000 – Capacity Building	34,000	43,500	43,500	43,500	43,500	208,000
6.2	Component K2000 – Demonstration projects	402,500	501,000	501,000	501,000	501,000	2,406,500
	Sub-total	436,500	544,500	544,500	544,500	544,500	2,614,500
7.0	National Programming						
7.1	Operations research	25,000	25,000	25,000	25,000	25,000	125,000
	Sub-total	25,000	25,000	25,000	25,000	25,000	125,000
	GRAND TOTAL BEFORE INFLATION	2,373,100	2,388,900	2,465,900	2,388,900	2,388,900	12,005,700
8.0	Inflation (3% per year from Year 2)		71,600	150,100	221,500	299,800	743,000
	GRAND TOTAL AFTER INFLATION	2,373,100	2,460,500	2,616,000	2,610,400	2,688,700	12,748,700

13.2 BUDGET NOTES

1. Management in Canada

This budget category includes:

- Fees for the Canada-based Project Director, internal monitoring and reporting, and project administration support. All fees are inclusive of benefits and overhead.
- Travel costs within Canada and to India for management and monitoring project activities..
- Office expenses, communications and printing costs in Canada.

2. Management and Operations in India

This category includes:

- Project accountant salaries for central (NACO) and state (Karnataka and Rajasthan) accounting activities.
- Support staff for the project office.
- Office rental, utility and supply costs.
- Local transportation costs.

3. Procurement

This category includes the purchase of capital equipment for the Karnataka and Rajasthan project offices in Year 1 of the project:

- Project vehicles (including partial replacement in Year 3, midway through the project).
- Office furniture and set-up of utilities.
- Computer equipment and software (including partial replacement/upgrade in Year 3, midway through the project).
- Photocopiers and fax machines.

4. Technical Assistance and Support

This component covers expenses to support the resident Canadian coordinators in their capacity-building roles in various project activities, as well as expenses to support Canadian, Indian and international technical advisors in various project activities.

5. Karnataka, Rajasthan and National Component Programming

These components describe the costs for the activity streams for the outputs in each component of the project. For each activity stream there are costs for technical assistance and programming costs. See the Budget by Activity below for more details.

13.3 BUDGET BY ACTIVITY

The Budget by Activity is exclusive of management costs in Canada and India, procurement costs and inflation. These latter items are included in the Budget by Component. All figures are in constant Canadian dollars (CAD).

Item	Component	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.0	**Karnataka Component Activities**						
	Output K1100						
	• Technical Assistance and Support	31,000	32,500	32,500	32,500	32,500	161,000
	• Programming Support	8,000	11,000	11,000	11,000	11,000	52,000
	Output K1200						
	• Technical Assistance and Support	71,000	75,000	75,000	75,000	75,000	371,000
	• Programming Support	18,000	21,500	21,500	21,500	21,500	104,000
	Output K1300						
	• Technical Assistance and Support	31,000	32,500	32,500	32,500	32,500	161,000
	• Programming Support	8,000	11,000	11,000	11,000	11,000	52,000
	Output K2100						
	• Technical Assistance and Support	70,000	72,500	72,500	72,500	72,500	360,000
	• Programming Support	100,000	125,000	125,000	125,000	125,000	600,000
	Output K2200						
	• Technical Assistance and Support	89,000	95,000	95,000	95,000	95,000	469,000
	• Programming Support	127,000	160,000	160,000	160,000	160,000	767,000
	Output K2300						
	• Technical Assistance and Support	70,000	73,500	73,500	73,500	73,500	364,000
	• Programming Support	100,000	125,000	125,000	125,000	125,000	600,000
	Output K2400						
	• Technical Assistance and Support	57,000	60,000	60,000	60,000	60,000	297,000
	• Programming Support	75,500	91,000	91,000	91,000	91,000	439,500
	Sub-total	**855,500**	**985,500**	**985,500**	**985,500**	**985,500**	**4,797,500**

Item	Component	Year 1	Year 2	Year 3	Year 4	Year 5	Total
2.0	**Rajasthan Component Activities**						
	Output R1100						
	• Technical Assistance and Support	31,000	32,500	32,500	32,500	32,500	161,000
	• Programming Support	8,000	11,000	11,000	11,000	11,000	52,000
	Output R1200						
	• Technical Assistance and Support	71,000	75,000	75,000	75,000	75,000	371,000
	• Programming Support	18,000	21,500	21,500	21,500	21,500	104,000
	Output R1300						
	• Technical Assistance and Support	31,000	32,500	32,500	32,500	32,500	161,000
	• Programming Support	8,000	11,000	11,000	11,000	11,000	52,000
	Output R2100						
	• Technical Assistance and Support	95,500	100,500	100,500	100,500	100,500	497,500
	• Programming Support	134,500	167,000	167,000	167,000	167,000	802,500
	Output R2200						
	• Technical Assistance and Support	95,500	100,500	100,500	100,500	100,500	497,500
	• Programming Support	134,500	167,000	167,000	167,000	167,000	802,500
	Output R2300						
	• Technical Assistance and Support	95,000	100,000	100,000	100,000	100,000	495,000
	• Programming Support	133,500	167,000	167,000	167,000	167,000	801,500
	Sub-total	**855,500**	**985,500**	**985,500**	**985,500**	**985,500**	**4,797,500**
3.0	**National Component Activities**						
3.1	**Output N1100**						
	• Technical Assistance and Support	31,600	34,500	34,500	34,500	34,500	169,600
	• Programming Support	12,500	12,500	12,500	12,500	12,500	62,500
3.2	**Output N1200**						
	• Technical Assistance and Support	24,100	27,000	27,000	27,000	27,000	132,100
	• Programming Support	12,500	12,500	12,500	12,500	12,500	62,500
	Sub-total	**80,700**	**86,500**	**86,500**	**86,500**	**86,500**	**426,700**
Grand	Total	**1,791,700**	**2,057,500**	**2,057,500**	**2,057,500**	**2,057,500**	**10,021,700**

14. PROJECT IMPLEMENTATION SCHEDULE

The project implementation schedule is given in the tables below, for Year 1 by month and for subsequent years by quarter. It is broken down into the four project components (Karnataka, Rajasthan, National and Management). These schedules will be modified during the first year of the project at the time of the inception report and the development of the first and second annual workplans.

Project Implementation Schedule, Karnataka Component, Year 1.

Activity	First Quarter			Second Quarter			Third Quarter			Fourth Quarter		
	1	2	3	4	5	6	7	8	9	10	11	12
Component K1000 – Capacity Building for KSAPS and implementers												
Output K1100 – Capacity to gather and analyze information.												
K1101 – Train in rapid epidemiologic assessment.					X	X						
K1102 – Train in collection and analysis of information.					X	X						
K1103 – Train in situational analysis.							X	X				
K1104 – Train/assist in directed policy research.												
K1105 – Train/assist in operational research.												
K1106 – Train/assist in monitoring and evaluation.												
K1107 – Train/assist in strategic planning.											X	X
Output K1200 – Capacity to implement HIV/AIDS programming												
K1201 – Train in best practices of targeted interventions							X	X				
K1202 – Train/assist in peer led interventions.										X	X	
K1203 – Assist in scaling up of interventions.												
K1204 – Train/assist in establishing VCT.										X	X	
K1205 – Train/assist in "grassroots" STI management.												
K1206 – Train/assist to integrate program activities.												
Output K1300 – Capacity to create an enabling environment for HIV/AIDS programming.												
K1301 – Increasing awareness of policy makers.			X	X								
K1302 – Involve vulnerable groups in programming.												
K1303 – Incorporate HIV into social change initiatives.							X	X	X			
K1304 – Train/assist in occupational health safety.												
K1305 – Train/assist in programming along a continuum												
K1306 – Develop training materials and methods.			X	X	X	X	X	X	X	X		

Activity	First Quarter			Second Quarter			Third Quarter			Fourth Quarter		
	1	2	3	4	5	6	7	8	9	10	11	12
Component K2000 – Implementation of Demonstration Project												
Output K2100 – Enhanced information base for programming, evaluation and monitoring												
K2101 – Select Project Area and build partnerships.	X	X	X	X	X	X	X	X	X	X		
K2102 – Zone and map the Project Area.										X	X	
K2103 – Review and document information base.							X	X	X	X		
K2104 – Strengthen selected laboratories.												
K2105 – Conduct baseline surveys and assessments.										X	X	
K2106 – Analyze and disseminate information.											X	X
K2107 – Develop a strategic plan for Project Area.												X
K2108 – Develop mechanisms for monitoring.												
Output K2200 – Development of community based participatory interventions.												
K2201 – Identify vulnerable groups and NGO partners.										X	X	X
K2202 – Train/mobilize NGOs and other implementers.										X	X	X
K2203 – Conduct assessment of vulnerable groups.											X	X
K2204 – Train peer educators and supervisors.												
K2205 – Implement interventions.												
K2206 – Evaluate outcomes and impacts.												
K2207 – Disseminate lessons learned and innovations.												
K2208 – Provide training resources/opportunities.												
Output K2300 – Development of a model for STI management at the "grassroots" level.												
K2301 – Baseline assessment of STI services.											X	X
K2302 – Select and partner with providers.												
K2303 – Train providers.												
K2304 – Develop a strategy for services to women.												
K2305 – Upgrade selected laboratory facilities.												
Output K2400 – Improved availability of high quality care and support.												
K2401 – Review current practices and resources.											X	X
K2402 – Identify priorities for improving care/support.											X	X
K2403 – Train care providers.												
K2404 – Strengthen VCT services in selected sites.												
K2405 – Support the development of PLWHA groups.												
K2406 – Assist NGOs to develop plans and proposals.												

Project Implementation Schedule, Rajasthan Component, Year 1.

Activity	First Quarter			Second Quarter			Third Quarter			Fourth Quarter		
	1	2	3	4	5	6	7	8	9	10	11	12
Component R1000 – Capacity Building for RSACS and implementers												
Output R1100 – Capacity to gather and analyze information.												
R1101 – Train in rapid epidemiologic assessment.					X	X						
R1102 – Train in collection and analysis of information.					X	X						
R1103 – Train in situational analysis.							X	X				
R1104 – Train/assist in directed policy research.												
R1105 – Train/assist in operational research.												
R1106 – Train/assist in monitoring and evaluation.												
R1107 – Train/assist in strategic planning.											X	X
Output R1200 – Capacity to implement HIV/AIDS programming												
R1201 – Train in best practices of targeted interventions							X	X				
R1202 – Train/assist in peer led interventions.										X	X	
R1203 – Assist in scaling up of interventions.												
R1204 – Train/assist in establishing VCT.										X	X	
R1205 – Train/assist in "grassroots" STI management.												
R1206 – Train/assist to integrate program activities.												
Output R1300 – Capacity to create an enabling environment for HIV/AIDS programming.												
R1301 – Increasing awareness of policy makers.			X	X								
R1302 – Involve vulnerable groups in programming.												
R1303 – Incorporate HIV into social change initiatives.							X	X	X			
R1304 – Train/assist in occupational health safety.												
R1305 – Train/assist in programming along a continuum												
R1306 – Develop training materials and methods.			X	X	X	X	X	X	X	X		

Activity	First Quarter			Second Quarter			Third Quarter			Fourth Quarter		
	1	2	3	4	5	6	7	8	9	10	11	12
Component R2000 – Implementation of Demonstration Projects												
Output R2100 – Development of a community-based participatory intervention for rural migrant men												
R2101 – Identify community of rural migrant men for intervention					X	X	X	X	X	X		
R2102 – Train and mobilize NGOs and other implementing partners										X	X	X
R2103 – Conduct baseline assessments of migrant population										X	X	X
R2104 – Train peer educators and supervisors												
R2105 – Implement interventions using an iterative approach												
R2106 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices												
R2107 – Provide resources and opportunities for hands on training for other implementers in interventions												
R2108 – Expand intervention to networked communities												
Output R2200 – Development of a community based participatory intervention for rural caste-based sex work												
R2101 – Identify community or area for intervention					X	X	X	X	X	X		
R2102 – Train and mobilize NGOs and other implementing partners										X	X	X
R2103 – Conduct baseline assessments of intervention population										X	X	X
R2104 – Train peer educators and supervisors												
R2105 – Implement interventions using an iterative approach												
R2106 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices												
R2107 – Provide resources and opportunities for hands on training for other implementers in interventions												
R2108 – Expand intervention to networked communities												
Output R2300 – Development of a Rajasthan model of the prevention-care continuum												
R2301 – Conduct a needs assessment and determine model site										X	X	X
R2302 – Identify and review best practice models that could be adapted										X	X	X
R2303 – Design and implement the model project using a participatory approach												
R2304 – Develop mechanisms for the ongoing evaluation of the model												
R2305 – Document and disseminate lessons learned and project impacts												
R2306 – Provide resources and opportunities for hands-on training												
R2406 – Assist NGOs to develop plans and proposals.												

Project Implementation Schedule, Karnataka Component, Years 2-5.

Activity	Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Component K1000 – Capacity Building for KSAPS and implementers																
Output K1100 – Capacity to gather and analyze information.																
K1101 – Train in rapid epidemiologic assessment.				X				X								
K1102 – Train in collection and analysis of information.					X				X							
K1103 – Train in situational analysis.	X	X	X	X												
K1104 – Train/assist in directed policy research.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
K1105 – Train/assist in operational research.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
K1106 – Train/assist in monitoring and evaluation.	X	X	X	X												
K1107 – Train/assist in strategic planning.																
Output K1200 – Capacity to implement HIV/AIDS programming																
K1201 – Train in best practices of targeted interventions.	X	X			X	X			X	X						
K1202 – Train/assist in peer led interventions.			X	X			X	X			X	X				
K1203 – Assist in scaling up of interventions.									X	X	X	X	X	X	X	X
K1204 – Train/assist in establishing VCT.		X	X	X	X								X		X	
K1205 – Train/assist in "grassroots" STI management.	X	X	X						X	X	X					
K1206 – Train/assist to integrate program activities.					X	X	X						X	X		
Output K1300 – Capacity to create an enabling environment for HIV/AIDS programming.																
K1301 – Increasing awareness of policy makers.	X		X		X		X		X		X		X		X	
K1302 – Involve vulnerable groups in programming.		X	X	X	X											
K1303 – Incorporate HIV into social change initiatives.				X				X				X				X
K1304 – Train/assist in occupational health safety.		X		X												
K1305 – Train/assist in programming along a continuum						X	X									
K1306 – Develop training materials and methods.	X		X		X		X		X		X		X		X	

Activity	Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Component K2000 – Implementation of Demonstration Project																
Output K2100 – Enhanced information base for programming, evaluation and monitoring																
K2101 – Select Project Area and build partnerships.																
K2102 – Zone and map the Project Area.						X		X								
K2103 – Review and document information base.						X		X								
K2104 – Strengthen selected laboratories.									X		X					
K2105 – Conduct baseline surveys and assessments.																
K2106 – Analyze and disseminate information.																
K2107 – Develop a strategic plan for Project Area.	X	X														
K2108 – Develop mechanisms for monitoring.	X	X														
Output K2200 – Development of community based participatory interventions.																
K2201 – Identify vulnerable groups and NGO partners.	X	X	X													
K2202 – Train/mobilize NGOs and other implementers.		X	X	X												
K2203 – Conduct assessment of vulnerable groups.			X	X	X											
K2204 – Train peer educators and supervisors.			X	X	X											
K2205 – Implement interventions.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
K2206 – Evaluate outcomes and impacts.													X	X	X	X
K2207 – Disseminate lessons learned and innovations.									X	X	X	X	X	X	X	X
K2208 – Provide training resources/opportunities.														X	X	X
Output K2300 – Development of a model for STI management at the "grassroots" level.																
K2301 – Baseline assessment of STI services.									X		X	X				
K2302 – Select and partner with providers.																
K2303 – Train providers.																
K2304 – Develop a strategy for services to women.				X	X	X		X	X		X	X	X			
K2305 – Upgrade selected laboratory facilities.						X	X	X	X	X						
Output K2400 – Improved availability of high quality care/support.																
K2401 – Review current practices and resources.	X	X	X													
K2402 – Identify priorities for improving care/support.			X	X												
K2403 – Train care providers.					X	X	X									
K2404 – Strengthen VCT services in selected sites.					X	X	X									
K2405 – Support the development of PLWHA groups.	X	X	X													
K2406 – Assist NGOs to develop plans and proposals.								X	X	X	X	X				

Project Implementation Schedule, Rajasthan Component, Years 2-5.

Activity	*Year 2*				*Year 3*				*Year 4*				*Year 5*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Component R1000 – Capacity Building for RSACS and implementers																
Output R1100 – Capacity to gather and analyze information.																
R1101 – Train in rapid epidemiologic assessment.																
R1102 – Train in collection and analysis of information.				X				X								
R1103 – Train in situational analysis.					X				X							
R1104 – Train/assist in directed policy research.	X	X	X	X												
R1105 – Train/assist in operational research.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
R1106 – Train/assist in monitoring and evaluation.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
R1107 – Train/assist in strategic planning.	X	X	X	X												
Output R1200 – Capacity to implement HIV/AIDS programming																
R1201 – Train in best practices of targeted interventions	X	X			X	X			X	X						
R1202 – Train/assist in peer led interventions.			X	X			X	X			X	X				
R1203 – Assist in scaling up of interventions.									X	X	X	X	X	X	X	X
R1204 – Train/assist in establishing VCT.		X	X	X	X								X		X	
R1205 – Train/assist in "grassroots" STI management.	X	X	X						X	X	X					
R1206 – Train/assist to integrate program activities.					X	X	X						X	X		
Output R1300 – Capacity to create an enabling environment for HIV/AIDS programming.																
R1301 – Increasing awareness of policy makers.	X		X		X		X		X		X		X		X	
R1302 – Involve vulnerable groups in programming.		X	X	X	X											
R1303 – Incorporate HIV into social change initiatives.				X				X				X				X
R1304 – Train/assist in occupational health safety.		X		X												
R1305 – Train/assist in programming along a continuum.						X	X									
R1306 – Develop training materials and methods.	X		X		X		X		X		X		X		X	

Activity	Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Component R2000 – Implementation of Demonstration Projects																
Output R2100 – Development of a community-based participatory intervention for rural migrant men																
R2101 – Identify community of rural migrant men for intervention.	X	X	X													
R2102 – Train and mobilize NGOs and other implementing partners.		X	X	X												
R2103 – Conduct baseline assessments of migrant population.			X	X	X											
R2104 – Train peer educators and supervisors.			X	X	X											
R2105 – Implement interventions using an iterative approach.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
R2106 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices.													X	X	X	X
R2107 – Provide resources and opportunities for hands on training for other implementers in interventions.									X	X	X	X	X	X	X	X
R2108 – Expand intervention to networked communities.														X	X	X
Output R2200 – Development of a community based participatory intervention for rural caste-based sex work																
R2201 – Identify community or area for intervention.	X	X	X													
R2202 – Train and mobilize NGOs and other implementing partners.		X	X	X												
R2203 – Conduct baseline assessments of intervention population.			X	X	X											
R2204 – Train peer educators and supervisors.			X	X	X											
R2205 – Implement interventions using an iterative approach.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
R2206 – Evaluate outcomes and impacts and disseminate innovations, lessons learned and best practices.													X	X	X	X
R2207 – Provide resources and opportunities for hands on training for other implementers in interventions.									X	X	X	X	X	X	X	X
R2208 – Expand intervention to networked communities.														X	X	X
Output R2300 – Development of a Rajasthan model of the prevention-care continuum																
R2301 – Conduct a needs assessment and determine model site.	X	X	X													
R2302 – Identify and review best practice models that could be adapted.		X	X	X	X											
R2303 – Design and implement the model project using a participatory approach.					X	X	X	X	X	X	X	X				
R2304 – Develop mechanisms for the ongoing evaluation of the model.					X	X	X									
R2305 – Document and disseminate lessons learned and project impact.												X	X	X		
R2306 – Provide resources and opportunities for hands-on training.									X	X	X	X	X	X	X	X
R2406 – Assist NGOs to develop plans and proposals.													X	X	X	X

Project Implementation Schedule, National Component, Year 1.

Activity	First Quarter			Second Quarter			Third Quarter			Fourth Quarter		
	1	2	3	4	5	6	7	8	9	10	11	12
Component N1000 – Capacity Building for NACO and Selected TRGs												
Output N1100 – Incorporation of international experience and expertise into national HIV/AIDS policy and programming by NACO and TRGs												
N1101 – Documentation of best practices				X	X	X	X	X	X	X	X	X
N1102 – Increase the utilization of best practices by NACO and TRGs											X	X
N1103 – Conduct directed research to inform decision-making					X	X		X	X		X	X
N1104 – Increase the use of evidence-based advocacy and policy formulation											X	X
Output N1200 – Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming by TRGs/NACO												
N1101 – Quantify impacts and costs of HIV/AIDS interventions in Rajasthan and Karnataka												
N1102 – Disseminate innovations and best practices to other state and local programs												
N1103 – Disseminate innovations and best practices nationally and internationally												

Project Implementation Schedule, National Component, Years 2-5.

Activity	Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Component N1000 – Capacity Building for NACO and Selected TRGs																
Output N1100 – Incorporation of international experience and expertise into national HIV/AIDS policy and programming																
N1101 – Documentation of best practices				X				X				X				X
N1102 – Increase the utilization of best practices	X				X				X				X			
N1103 – Conduct directed research to inform decision-making		X		X		X		X		X		X		X		X
N1104 – Increase the use of evidence-based advocacy and policy	X				X				X				X			
Output N1200 – Incorporation of innovations from state and local level demonstration projects into national HIV/AIDS programming																
N1101 – Quantify impacts and costs of HIV/AIDS interventions in Rajasthan and Karnataka							X	X	X	X	X	X	X	X	X	X
N1102 – Disseminate innovations and best practices to other state and local programs								X		X			X	X	X	X
N1103 – Disseminate innovations and best practices nationally and internationally													X	X	X	X

15. PROJECT REPORTING

15.1 GENERAL

The Project Director in Winnipeg will have overall responsibility for liaison with and reporting to CIDA on the project's technical and financial progress. Reports will focus on progress towards achievement of results. It is proposed to provide progress reports on a semi-annual basis. While monthly expenditure accounting will be provided with monthly invoicing to CIDA, the financial reports will also be semi-annual.

Reporting will be linked with CIDA's fiscal year as follows:

- The annual workplan will be for the period between April 1 of one year and March 31 of the next.
- A semi-annual report will cover the period April to September of each fiscal year.
- An annual report will cover the entire fiscal year (April to March).

15.2 ANNUAL WORKPLAN AND BUDGET

Since this Project Implementation Plan (PIP) has been prepared following the Design Mission, only a preliminary design framework for the project could be developed with project partners in India. The project design will be reviewed and revised within the first three to six months after implementation, including in particular a revised first year workplan.

- All subsequent annual workplans will cover a fiscal year, and will be prepared in the month of February prior to the beginning of the fiscal year and submitted to CIDA at the beginning of March each year for finalization by the end of March. The annual workplan will include:
- A listing and detailed description of each activity to be carried out during the year, as per the WBS, and a schedule of implementation.
- The planned achievements for the year – the expected outputs and progress towards achievements of the outcomes.
- The resources required to carry out the activities – list of materials and professional services required.
- A procurement plan.
- A personnel deployment plan.

- Planned expenditures for project activities, including actual disbursement for previous years and an updated budget for the remaining years of the project.

15.3 Semi-Annual Progress and Financial Status Report

This report will be prepared on the basis of the data collected on the indicators identified in the PMF. This report will be submitted at the end of October for the period April-September. It will include:

- For each activity, progress in achieving results and deviation from the original plan.
- For each activity, financial status and deviation from the original plan.
- Explanation of deviations, in results and expenditures, from what were planned.
- Discussion of contextual changes, issues, problems, assumptions, risks and associated implementation challenges, and how they will deal with.
- Minutes of PSC or any other important meetings held during the period and actions taken.

15.4 Annual Report

The Annual Report will also be prepared on the basis of data collected on the indicators identified in the PMF. This report will be submitted once a year, at the end of May, and will cover the fiscal year just completed. It will include:

- Progress towards achievement of each outcome against the original plan and a discussion of deviations from the plan, with explanations.
- Technical progress since the beginning of the Project.
- For each activity, progress in achieving results and deviation from the original plan.
- For each activity, financial status and deviation from the original plan.
- Explanation of deviations, in results and expenditures, from what were planned.
- Discussion of contextual changes, issues, problems, assumptions, risks and associated implementation challenges, and how they will deal with.
- Minutes of PSC or any other important meetings held during the period and actions taken.
- How the overall project, its results, beneficiaries and budget may be changing from what was envisioned.

15.5 END-OF-PROJECT REPORT

An end-of-project report will be produced within three months of project completion. In addition to including the points addressed in the annual reports, it will focus particularly on progress towards achieving the project impact.

15.6 OTHER REPORTS

In addition to the above-mentioned regular reports, the following reports will be submitted to CIDA, as and when they are produced.

- Consultant reports on special assignments.
- Training workshop reports and evaluations conducted by the project and, where relevant, by NACO, KSAPS, RSACS and other donors.

16. PROCUREMENT PLAN

Procurement for the project will consist primarily of project vehicles, office furniture, equipment and accessories. All of these items are manufactured and are readily available in India. It is therefore recommended that for cost-effective procurement and maintenance, as well as for system compatibility, they all be procured in India. Procurement of most of the major items will be effected during the first year of the project. Some minor ongoing procurement will be necessary, particularly partial replacement of vehicles and partial replacement or upgrades of computer equipment. These items will be identified in the semi-annual and annual reports. The project office in each state will carry out the procurement in accordance with CIDA procurement guidelines. At the end of the project, CIDA will be provided with a list of the all the equipment purchased with project funds and will recommend to CIDA a method for disposal of these assets in accordance with CIDA guidelines.

The following table represents the planned procurement for the first year.

PROCUREMENT TABLE

Item No.	Description	Total Quantity	Unit Cost Can $	Total Cost Can $	Intended Time of Purchase
1. Project Vehicles					
1.1	Vehicles: 4x4	6 in Year 1, 3 in Year 3	$19,000	$171,000.00	Commencement, with partial replacement in Year 3
	Total Project Vehicles			**$171,000.00**	
2. Office Furniture and Equipment, and Furnishings					
2.1	Office furniture and renovations for project offices	2 sets	$20,000	$44,000.00	Commencement
2.2	Computer stations, including printers	8 in Year 1, 4 in Year 3	$5,000	$60,000.00	Commencement, with partial replacement/ Upgrade, Year 3
2.3	Photocopiers	2	$3,500	$7,000.00	Commencement
2.4	Fax Machines	2	$1,500	$3,000.00	Commencement
2.5	Office Air-conditioners	8	$1,000	$8,000.00	Commencement
2.6	Telephone systems	2	$1,000	$2,000.00	Commencement
2.7	Television/VCR	2	$1,500	$3,000.00	Commencement
2.8	Audio-visual systems for training	2 sets	$5,000	$10,000.00	Commencement
2.9	Miscellaneous kitchen equipment	2 sets	$1,000	$2,000.00	Commencement
2.10	Furnishings			$14,000.00	Commencement
	Total Office Furniture and Equipment, and Furnishings			**$153,000.00**	
	Total Project Procurement			**$324,000.00**	

17. FIRST ANNUAL WORKPLAN

The basic elements of the first year workplan are contained in this Project Implementation Plan. A detailed workplan will be provided at the time of the inception report, within the first six months of project implementation. The project's work breakdown structure and description of outputs and activities are described in Sections 7 to 10 above, and the planned activities for the first year appear in the project implementation schedule in Section14. The planned first year budget is given in Section 13, with first year procurement in Section 16. The planned first year achievements are described below.

17.1 PLANNED FIRST YEAR ACHIEVEMENTS

17.1.1 Karnataka Component

Component K1000 – Capacity Building for KSAPS and implementers

Within the first year, initial training and support will have been provided for KSAPS and implementers in the following areas:

- Rapid epidemiologic assessment (K1101).
- Collection and analysis of information (K1102).
- Preparation of situational analyses (K1103).
- Population-based strategic planning (K1107).
- Best practices of targeted interventions (K1201).
- Design and implementation of participatory peer-led HIV prevention interventions (K1202).
- Principles and strategies for the establishment of voluntary counselling and testing programs (K1204).

In addition, a number of activities to increase the capacity to create an enabling environment for HIV/AIDS programming (Output K1300) will have been undertaken. These include:

- Activities to increase the awareness of policy makers.
- Training in strategies for incorporating HIV issues into social change initiatives.
- Development of high quality training materials and methods.

Component K2000 – Implementation of the Demonstration Project

Within the first year, a number of initial activities will be conducted in support of the implementation of the district level demonstration project. These include:

- Selection of the project area and the establishment of partnerships with implementers and community members (K2101).
- An initial exercise in the zoning and mapping of the project area (K2102).
- A review and documentation of the information base (K2103).

- The conduct of preliminary baseline surveys and assessments (K2105).
- Analysis and dissemination of information from preliminary baseline surveys and assessments (K2106).
- Identification of vulnerable groups and potential NGO implementing partners (K2201).
- Initial training and support for implementing partners in the development of community-based interventions (K2202).
- An initial assessment of vulnerable population groups (K2203).
- A baseline assessment of STI services (K2301).
- A review of current care and support practices and resources (K2401).
- An initial identification of priorities for improving care and support services (K2402).

17.1.2 Rajasthan Component

Component K1000 – Capacity Building for KSAPS and implementers

The first year achievements in this component will be similar to those in Karnataka (see above). They include training and support in:

- Rapid epidemiologic assessment (R1101).
- Collection and analysis of information (R1102).
- Preparation of situational analyses (R1103).
- Population-based strategic planning (R1107).
- Best practices of targeted interventions (R1201).
- Design and implementation of participatory peer-led HIV prevention interventions (R1202).
- Principles and strategies for the establishment of voluntary HIV counselling and testing programs (R1204).

The planned first year achievements in creating an enabling environment in Rajasthan (Output R1300) are also the same as those in Karnataka and include:

- Activities to increase the awareness of policy makers.
- Training in strategies for incorporating HIV issues into social change initiatives.
- Development of high quality training materials and methods.

Component R2000 – Implementation of Demonstration Projects

For the implementation of the community-based interventions for rural migrant men (Output R2100) and rural caste-based sex work (R2200), the following activities will be conducted in the first year.

- Identification of communities for the implementation of interventions (R2101 and R2201).
- Initial training and mobilization of NGOs and other implementing partners (R2102 and R2202).
- Conduct of initial assessments of the intervention populations (R2103 and R2203).

For the development of a Rajasthan model of the prevention-care continuum, the following activities will be conducted in the first year:

- A needs assessment and selection of a model site (R2301).
- Initial identification and review of best practice models that could be adapted (R2302).

17.1.3 National Component

At the national level, the following activities will be conducted during the first year:

- Documentation of best practices from India and elsewhere (N1101).
- Work with NACO and TRGs to support the utilization of best practices (N1102).
- The conduct of selected policy-relevant operations research to inform decision-making (N1103).
- Activities to increase the use of evidence in advocacy and policy formulation (N1104).

17.1.4 Project Management Component

The following activities will be conducted in the first year in relation to project management:

- Development of systems for internal project monitoring.
- Establishment of financial systems for disbursement of funds and funds flow.
- Mobilization and relocation of Resident Canadian Coordinators to India.
- Establishment of project offices and procurement of equipment in Rajasthan and Karnataka.
- Hiring of Indian support staff and technical advisors.
- Establishment of the Canadian management office and support services.