KHPT

Karnataka Health Promotion Trust

Annual Report 2012-13

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Abbreviations

AC	:	Advocacy Coordinator
ADC	:	Assistant Deputy Commissioner
AGM	:	Annual General Body Meeting
AIDS	:	Acquired Immunodeficiency Syndrome
AMICAALL	:	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ANC	:	Ante Natal Care
ART	:	Anti Retroviral Therapy
ASHA	:	Accredited Social Health Activist
AWW	:	Anganwadi Worker
BATS	:	Bureau of AIDS, TB and STI
BMC	:	BioMed Central
BMGF	:	Bill and Melinda Gates Foundation
BoD	:	Board of Directors
BPM	:	Block Program Manager
BST	:	Basava Seva Trust
CARDTS	:	Citizens Alliance for Rural Development and Training Society
CBO	:	Community Based Organisation
CBTS	:	Community Behaviour Tracking Survey
CCC	:	Community Care Centre
CCOORR	:	Christian Council for Rural Development and Research
CDPO	:	Child Development Project Officer
CEO	:	Chief Executive Officer
CM	:	Community Mobilisation
FLWs	:	Frontline workers
FSW	:	Female Sex Worker
G**BV**	:	Gender Based Violence
GF	:	Global Fund
GFATM	:	Global Fund to fight AIDS, Tuberculosis and Malaria
GI-CASH	:	Gender Integration and Committee against Sexual Harassment
GoI	:	Government of India
GoK	:	Government of Karnataka
GSPP	:	Gender Sensitization and People Friendly Police Project
HBMNC	:	Home Based Maternal and Newborn Care

Abbreviations

HIV	:	Human Immuno-deficiency Virus
HMIS	:	Health Management Information System
HPS	:	Higher Primary School
HRD	:	Human Resource Development
HRGs	:	High Risk Groups
IAS	:	Indian Administrative Services
IASE	:	Institute for Advanced Studies in Education
IBBA	:	Integrated Behaviour and Biological Assessment
ICMR	:	Indian Council of Medical Research
ICPS	:	Integrated Child Protection Scheme
ICRW	:	International Centre for Research on Women
ICTC	:	Integrated Counselling and Testing Centres
IEC	:	Information, Education and Communication
MOHFW	:	Ministry of Health and Family Welfare
MOH	:	Ministry of Health
MoU	:	**Memorandum of Understanding**
MOWCD	:	Ministry of Women and Child Development
MSACS	:	Maharashtra State AIDS Control Society
NACA	:	National Agency for the Control of AIDS
NACO		:National AIDS Control Organisation
NACP		:National AIDS Control Program
NGO	:	Non Governmental Organisation
NIMHANS	:	National Institute of Mental Health and Neuro Sciences
NLSIU	:	National Law School of India University
NPIP	:	Non Paying Intimate Partners
NRHM	:	National Rural Health Mission
OD	:	Organisational Development
OI	:	Opportunistic Infection
OP	:	Out Patient
OVC	:	Orphan and Vulnerable Children
PBS	:	Polling Booth Survey
PFI	:	Population Foundation of India
PHC	:	Primary Health Centre
PNC	:	Post Natal Care
PO	:	Program Officer
Pop Council	:	Population Council
PPP	:	Public Private Partnership
PPTCT	:	Prevention of Parent To Child Transmission
SJRI	:	St. John Research Institute

SRH	:	Sexual and Reproductive Health
STD	:	Sexually Transmitted Disease
SLP	:	State Lead Partner
SOPs	:	Standard Operating Procedures
SP	:	Superintendent
SPAD	:	Society for People Action for Development
TACAIDS	:	Tanzania Commission for AIDS
TAN	:	Tax deduction and collection Account Number
TB	:	Tuberculosis
TG	:	Transgenders
TI	:	Targeted Intervention
TOC	:	Theory of Change
TOT	:	Training of Trainers
TSU	:	Technical Support Unit
TV	:	Television
T**WG**	:	Technical Working Group
UAC	:	Uganda AIDS Commission (UAC)
UNDP	:	United Nations Development Programme
UNESCO	:	United Nation Educational, Scientific and Cultural Organisation
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
UNTF	:	United Nations Trust Fund
CFAR	:	Centre for Advocacy and Research
CGPH	:	Centre for Global Public Health
CMIS	:	Computerised Management Information System
CMT	:	Crisis Management Team
CSC	:	Care and Support Centre
CSO	:	Civil Society Organisation
CTE	:	Government College of Teachers' Education (CTE)
DAPCU	:	District AIDS Prevention and Control Unit
DDPI	:	Deputy Director, Public Instruction
DFID	:	Department of International Development
DIA	:	District Implementing Agency
DPC	:	District Project Coordinator
DPM	:	District Program Manager
DPS	:	District Program Specialist
DRP	:	District Resource Person
DSERT	:	Department of State Educational Research and Training
ETT	:	Enumeration and Tracking Tool

Abbreviations

FFC	:	Family Focused Communication
FGD	:	Focused Group Discussion
FHI	:	Family Health International
FIGO	:	International Federation of Gynecology and Obstetrics
IHAT	:	Indian Health Action Trust
ILN	:	India Learning Network
IMNCI	:	Integrated Management of Neo-natal and Childhood Illness
IP	:	In Patient
IP	:	Intimate Partner
IPD	:	In Patient Department
IPV	:	Intimate Partner Violence
IRB	:	Institutional Review Board
ITPA	:	Immoral Traffic Prevention Act
JD	:	Joint Director
KHPT	:	Karnataka Health Promotion Trust
KJA	:	Karnataka Judicial Academy
KMS	:	Kranti Mahila Sangha
KP	:	Key Population
KROSS	:	Karnataka Regional Organistion for Social Service
KSAPS	:	Karnataka State AIDS Prevention Society
LS	:	Learning Site
LSHTM	:	London School for Hygiene and Tropical Medicine
LWS	:	Link Worker Scheme
M and E	:	Monitoring and Evaluation
MARPS	:	Most at Risk Population
MCTS	:	Mother-Child Tracking System
MNCH	:	Maternal Neonatal Child Health
PRI	:	Panchayati Raj Institutes
PSS	:	Parivar Seva Sansatha
PTS	:	Post Transition Support
PWDVA	:	Protection of Women from Domestic Violence Act
RCT	:	Randomised Control Trial
RNTCP	:	Revised National TB Control Program
RPC	:	Research Program Consortium
RPs	:	Resource persons
RRC	:	Red Ribbon Club
RTI	:	Reproductive Tract Infection
RTI	:	Research Triangular Institute
RCH	:	Reproductive and Child Health

STI	:	Sexually Transmitted Infections
SC/ST	:	Schedule Caste/Schedule Tribe
SCMT	:	Supportive Community Monitoring Team
SACS	:	State AIDS Control Society
SBA	:	Skilled Birth Attendant
SCMT	:	Supportive Community Monitoring Tool
SDMC	:	School Developmental Management Committee
SG	:	Support Group
SHG	:	Self Help Group
SIDA	:	Swedish International Development Agency
UNTFEVAW	:	United Nations Trust Fund to End Violence Against Women
UoM	:	University of Manitoba
USAID	:	United States Aid for International Development
VAW	:	Violence Against Women
VHC	:	Village Health Committee
VHSC	:	Village Health and Sanitation Committee
VMS	:	Vijay Mahila Sangha
WB	:	World Bank
WCD	:	Women and Child Development
WHO	:	World Health Organisation
ZAC	:	Zanzibar AIDS Commission

Section 1

Overview of KHPT

Section 1 Overview of KHPT

1.1 About KHPT

1.1.1. Background

Karnataka Health Promotion Trust (KHPT) was formed in 2003 as a partnership between the Karnataka State AIDS Prevention Society (KSAPS) and the University of Manitoba (UoM), Canada (Karnataka Health Promotion Trust).

1.1.2. Vision

"Empowered communities, in Karnataka and India, including women and men, girls and boys, working collectively to improve their health, reduce the incidence and burden of Human Immuno-deficiency Virus /Acquired Immuno-deficiency Syndrome (HIV/AIDS), and assert their rights and dignity (About KHPT)."

1.1.3. Mission

- "Reduce the incidence and burden of HIV/AIDS through the delivery of evidence-based, results- oriented, comprehensive, gender transformative, sustainable and scaled HIV/AIDS prevention, care and support programmes and services, built in partnership with the communities which we serve.
- Strengthen the capacity of partners, including community-based, governmental and non-governmental organizations, to plan, deliver, monitor and evaluate HIV/AIDS prevention, care and support programs.
- Develop as a learning organization, continually improving our knowledge and approaches through reflection, research and engagement with our peers, in India and globally (About KHPT)."

1.2. Briefs about projects

1.2.1. India Learning Network (ILN) (Jan 2012-Dec 2014)

KHPT in partnership with Family Health International (FHI) and University of Manitoba works to establish a learning network to disseminate learning from India in HIV prevention to other countries in Africa and Asia (Director Communications, KHPT Annual report 2011-12 , 2013).

1.2.2. Link Worker Scheme (LWS)- Maharashtra (Nov 2012- Mar 2014)

The National AIDS Control Organisation(NACO) aims to build a community-centred model for integrating HIV prevention, care, support and treatment for rural

populations. The specific objective of the program is to "reach out to High Risk Groups (HRGs) and vulnerable men and women in rural areas with information, knowledge, and skills to prevent and control Sexually Transmitted Infections (STI) and HIV (NACO, Link Worker Scheme and Operational Guidelines, 2009)." KHPT in partnership with Maharashtra State AIDS Control Society (MSACS) implements this program in Maharashtra as the State Lead Partner (SLP) in 25 districts.

1.2.3. Sabala project (Jul 2013-2017)

KHPT works with adolescent children of female sex workers in northern Karnataka, with the aim of retaining them in school, in order to delay their entry into sex work, with the funding support from World Bank (Director Communications, KHPT Annual report 2011-12 , 2013).

1.2.4. Sampoorna-Link Worker Scheme (LWS) -KSAPS (Sept 2009 to Mar 2014)

KHPT in partnership with Karnataka State AIDS Prevention Society implements this project in eight 'A' category districts in Karnataka to develop a comprehensive integrated rural program that provides HIV/AIDS prevention, care and support to at risk and vulnerable populations (Director Communications, KHPT Annual report 2011-12, 2013).

1.2.5. Samvedana (Nov 2012-Dec 2014)

KHPT works in partnership with National Law School of India University (NLSIU), Karnataka Judicial Academy (KJA), Centre for Advocacy and Research(CFAR), National Institute of Mental Health and Neuro Sciences(NIMHANS) and Community Based Organizations (CBOs) for this project. The project works towards addressing violence against women in sex work in 30 districts of Karnataka. Through the project, KHPT works with the police, media and the judiciary, in addition to an intervention component focusing on intimate partner violence (Director Communications, KHPT Annual report 2011-12, 2013).

1.2.6. Samvedana Plus (Apr 2013-2016)

Samvedana plus was designed to pilot a model with both intervention and evaluation components on understanding intimate partner violence (IPV) and HIV risk to enable advocacy on gender-based violence against FSWs in the context of HIV prevention.

1.2.7. Sankalp Phase II- Post Transition Support (2012-2013):

KHPT provides continued support to KSAPS and the transitioned Targeted Interventions (TIs) for sustained quality in program management to KSAPS and

institution building of the Community Based Organizations (CBOs) through cross learning forums, documenting and dissemination of best practices, conduct of outcome assessments and support to Public Private Partnership (PPP)-Integrated Counseling and Testing Centre (ICTC) within selected TIs.

1.2.8. SPRUHA (Jan 2008-Mar 2013)

KHPT scaled up HIV care services through Community Care Centres (CCCs) in Maharashtra and Karnataka as a sub-recipient to NACO and Global Fund to fight AIDS, Tuberculosis and Malaria under round VI and RRC funding. The project aims that increased number of PLHIV have access to better quality of life and reduced vulnerability through improved clinical and care services, linking with relevant social services and community responses. The CCCs provide the range of medical & psychosocial services either directly or through strong linkages with relevant identified service providers such as ART centre, ICTC, DOTS, TI programs, Tertiary level hospitals, orphanages, destitute homes, vocational rehabilitations centres, legal support centres in their respective districts.

1.2.9. Sukshema project-Maternal and Neonatal Child Health (MNCH) Program (Oct 2009- Sept 2014):

KHPT in partnership with Government of Karnataka's National Rural Health Mission (NRHM) focuses on improving maternal, neonatal and child health outcomes in eight most backward districts in Karnataka, through development and adoption of effective and operational health system approaches (Director Communications, KHPT Annual report 2011-12 , 2013).

1.3. Research initiatives brief

1.3.1. An Assessment of Sexual and Reproductive Health (SRH) needs of HIV infected adolescents in six districts of Karnataka State (Mar 2012-Mar 2013).

KHPT conducted this study commissioned by Indian Council of Medical Research (ICMR) in partnership with KSAPS, Snehadaan, Bangalore and JJM Medical College, Davangere. The objectives of the study were to assess the Sexual and Reproductive Health (SRH) needs of adolescents living with HIV, assess the parents or guardians and care providers' perspective towards adolescent SRH needs and assess existing HIV/AIDS treatment, care and support programs and identify information and services gaps in relation to SRH for HIV positive adolescents (Director Communications, KHPT Annual report 2011-12 , 2013)

1.3.2. An Assessment of the burden of pediatric HIV in "A" category districts in India(Aug 2012- Nov 2014):

KHPT implements this task force study of the ICMR in partnership with NACO, KSAPS and St. John's Research Institute, Bangalore to estimate the overall burden of pediatric HIV in a high prevalence district in India (Director Communications, KHPT Annual report2011-12, 2013).

1.3.3. CHARME:

CHARME I aimed to study the dynamics of HIV transmission and the impact of HIV preventive interventions in the four southern states of India covered by Avahan (Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu). CHARME II aimed to assess HIV transmission dynamics and the collective impact of all HIV prevention programming in Andhra Pradesh and Karnataka, and enhance relevant analytical capacity within India (Director Communications, KHPT Annual report 2011-12, 2013).

1.3.4. Experience of violence and HIV related risks and vulnerability among women in sex work in Karnataka (2012-2013)

The overall aim of this study was to analyze the current level of violence among sex workers and its relationship with sex work characteristics and associated risks and vulnerabilities under the umbrella of community empowerment. The study was funded by Sankalp project. (KHPT, Experience of violence and HIV related risks and vulnerability among women in sex work in Karnataka: Understanding the role of self empowerment and power relations with community , 2013).

1.3.5. STRIVE(2011-2017):

STRIVE, Tackling Structural Drivers of HIV Epidemic, Research Programme Consortium is a research consortium based at the London School for Hygiene and Tropical Medicine (LSHTM), with partners in India, Tanzania and South Africa. KHPT is one of the partners. The project focuses on understanding and evaluating how structural factors such as stigma, gender-based violence, poverty and alcohol drinking habits influence vulnerability to HIV transmission and undermine prevention efforts (Director Communications, KHPT Annual report 2011-12, 2013).

1.3.6. Understanding the Sexual & Reproductive Health (SRH) needs of female sex workers (FSWs) & factors determining their access to services- supported by ICMR (Jul' 2012- Nov' 2013):

KHPT implemented this study in partnership with the sex worker community and local NGOs to explore various dimensions of SRH among FSWs.

Section 2

Key projects

Section 2 Key projects

2.1. India Learning Network- Bridge project

2.1.1. Project Profile

2.1.1.1. Partners

Family Health International (FHI) 360, University of Manitoba (UoM)

2.1.1.2. Funders

Bill and Melinda Gates Foundation

2.1.1.3. Project Duration

Jan' 2012 – Dec' 2014

2.1.1.4. Area of work

- Tier I Countries in Africa: Nigeria, Tanzania and Uganda
- Tier II Countries in Asia: Bangladesh, Sri Lanka and Thailand

2.1.1.5. Target Community

Representatives from international agencies, local NGOs, government and community representatives.

2.1.1.6. Goal of the project

The goal of the project is to influence global HIV prevention practice by disseminating widely the approaches and learning from scaled HIV prevention interventions in India.

2.1.1.7. Objectives of the project:

- To enhance the capacities of HIV programmers, policy makers and implementers from selected countries through exposure to lessons from scaled HIV prevention implementation under Avahan and India.
- To accelerate and deepen the dissemination of learning from site visits by providing limited in-country technical assistance and other follow-up support.

2.1.1.8. Background of the project

"African and Asian countries have varied and comprehensive experience in HIV program management. Africa globally leads the way for scaled up HIV care and treatment programs in generalized epidemics and Asia has diverse capacities in multi-

pronged HIV prevention and care programs. India specifically has extensive experience in (implementing and scaling up) prevention interventions in concentrated epidemics. An interactive and focused exchange of learning can lead to increased knowledge and improved practical skills, with an emphasis on tangible examples of effective addressal of challenges (Our projects)." 2.1.2. Activities/Outcomes of the project

2.1.2. Activities and outcomes

2.1.2.1. Guided Learning Visits

- Tier I Africa (Nigeria, Tanzania & Uganda): the visits under the project were organised to provide the participants exposure to India HIV/AIDS program. The visits provided the participants with an opportunity to interact with representative from the National Program, State AIDS Control Society, Karnataka (SACS), communities and stakeholders.

Figure 2.1: World Map and countries relevant to ILN bridge project

Photo 2.1: Visit of delegates from Uganda, 26th Aug –31st Aug'2012

Photo 2.2: Visit of delegates from Tanzania, 8th Oct –12th Oct' 2012

Table 2.1: Visits organized (ILN project)

Dates	Country	Organisation	Number of members
4th Jun – 8th Jun'2012.	Nigeria	National AIDS Control Agency(NACA) & Technical Working Group (TWG)	12 members delegation
27th Aug- 31st Aug'2012.	Uganda	Parliament Committee of HIV/AIDS and related matters, Uganda AIDS Commission (UAC), Ministry of Health, United Nations Population Fund (UNFPA), United Nations Development Program (UNDP) and NGOs- Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) and Most at Risk Population (MARPS) Network	8 members delegation
8th Oct -12th Oct'2012	Tanzania	Tanzania Commission for AIDS(TACAIDS), National AIDS Control Program (NACP), Zanzibar AIDS Commission (ZAC), UNAIDS and Non Government Organisations (NGOs).	11 members delegation

2.1.2.2. Technical Assistance Provided:

- Tier I Africa (Nigeria, Tanzania & Uganda): Tier I country requested the project to support development for feedback on documents.
  - The project worked with the National Agency for the Control of AIDS (NACA) and Technical Working Group (TWG) to develop National HIV Prevention Guidelines for FSWs in Nigeria.
  - The project reviewed and contributed to National Multisectoral Strategic Framework III documents for Tanzania.

- Inputs were provided for advocacy documents for Zanzibar.
- Support was provided to Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) for mapping of MARPS in Kampala city by developing mapping protocols, Monitoring and Evaluation (M and E) and reporting formats.
- Concept note on developing Learning Site (LS) and guidelines was shared with Uganda AIDS Commission, Ministry of Health (MOH) and UNAIDS.
- Support was provided to the MARPS Network in Uganda to map MARPS populations across the country.

- Tier II Asia (Thailand, Bangladesh & Sri Lanka) provided:
  - A workshop was organized on developing National Guidelines and Standard Operating Procedures (SOPs) for HIV Prevention among Key Affected Populations in Thailand in Apr'2012.
  - Review and final comments on MSM guidelines were completed and shared with Thailand MOH/Bureau of AIDS, TB and STI (BATS) by Jan'2013.
  - A workshop was held in Thailand on 20th Mar-21st Mar'2013 to help redesign the key population (KP) intervention programs to make them more effective and efficient in Thailand.
  - Initial visit to Sri Lanka was facilitated by the UNAIDS country office in Dec' 2012.
  - Conversations on further opportunities for Technical Assistance to Bangladesh were initiated with UNAIDS local country office in Oct' 2012.

2.1.2.3. Alternate Learning Systems

The progress included UoM working with FHI 360 & Population Council (Pop Council) in setting up the web based learning programs for the Bridge Project. The virtual learning topics were selected based on the priority and program needs of the member countries.

The activities were:

- E-forums: UoM introduced participants from all Tier I & II countries to the Google Groups e-forums. The forum had discussion on issues on micro planning, peer led outreach, and mapping techniques.
- Webcast: UoM developed a webcast on micro planning shortly.
- On line Resource Directory: UoM compiled resources related to Avahan programs in Karnataka and shared the same with Pop Council to be put onto the India HIV portal.
- HIV Portal: The online portal had been initiated and is accessible via the following link www.indiahiv.org.

2.1.3. Achievements:

- 31 participants from Tier 1 Countries in Africa visited the India programs between Apr' 2012- Mar'2013. 3 scoping visits to understand the local HIV programs, scenario and to build relationships were made.
- Technical Assistance visits were made to Tanzania in Nov' 2012 to develop a roadmap of Technical Support to TACAIDS and ZAC.
- 25 participants were active on the e-learning initiatives from Tier 1 countries.

2.1.4. Publications

- Girish, M. and Washington, R. (2013); Scaling up Community Friendly STI/ Reproductive Tract Infection (RTI) Services for Most at Risk Populations- An Avahan India Experience; Bangalore, KHPT.

2.1.5. Lessons learnt

- There was an interest in adapting the Avahan India experience.
- Lessons and systems were replicable with modification to suit the local context.
- Need to work with critical stakeholders beyond the National Program.
- Coordination with Global Fund (GF)/WB/USAID and other donors was found to be critical.
- It was critical to be part of TWG to influence policy.

2.2. LWS- Maharashtra

2.2.1. Project Profile

2.2.1.1. Partners

Maharashtra State AIDS Control Society (MSACS)

Implementing partners: Priyadarshani Gramin and Adivashi Sevabhavi Sanstha, Sangamner, Bhagyodaya Arogya & Bahuuddeshiya Shikshan Sanstha, Marathwada Gramin Vikas Sanstha, Maharashtra Samajik Vikas Trust, Pen-Raigad, Jai Laxmi Shikshan Sanstha, Socio Economic Development Trust, Prakashyatri, Aadhar Bahuddeshiya Sanstha,Amalner, Lotus Medical Foundation, CRTDP, Noble Shikshan Sanstha, Magmo Welfares Sanstha Nashik, Swayam Shikshan, Prayog, Community Aid & Sponsorship Program, NSP plus Association, Satara, Param Prasad Charitable Society, Social Action for Literacy & Health, Jankalyan Vikas Mandal, Matrubhumi Multipurpose Foundation, Jansahyog Pratishthan,Dondaicha, RTM SAP Mandal, Kayadhu Gram Vikas Pratisthan, Network Of Beed By People Living With HIV/AIDS, Marathwada Gramin Vikas Sanstha , Gunvant Shikshan Sanstha

2.2.1.2. Funders:

GFATM- NACO, MSACS

2.2.1.3. Project Duration

1st Nov' 2012 - 31st Mar'2014 (Prior to Nov 2012, the LWS programme was being implemented by AVERT Society and MSACS)

2.2.1.4. Area of work:

- The area of work for the project is 25 districts of Maharashtra, i.e. Ahmednagar, Akola, Aurangabad, Raigad, Bhandara, Prabhani, Ratnagiri, Jalgaon, Jalna, Kolhapur, Nagpur, Wardha, Nashik, Osamanabad, Pune, Satara, Solapur, Thane, Nanded, Buldana, Amravati, Dhule, Hingoli, Beed and Washim.

2.2.1.5. Target Community

PLHIV FSW, MSM, TG, Truckers, Migrants, Orphan and Vulnerable Children (OVC).

2.2.1.6. Goal of the project

The scheme makes an effort to build a community-centred model for rural areas. This includes an outreach strategy to address the HIV prevention, care and support and treatment requirements.

2.2.1.7. Objectives of the project

The specific objective of the scheme is to "reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction."

This entails:

- "Increasing the availability and use of condoms among HRGs and other vulnerable men and women.
- Establishing referral and follow-up linkages for various services including treatment for STIs, testing and treatment for TB, ICTC/PPTCT services, HIV care and support services including ART.
- Creating an enabling environment for PLHA and their families, reducing stigma and discrimination against them through interactions with existing community structures/groups, e.g. Village Health Committees (VHC) , Self Help Groups (SHG) and Panchayati Raj Institutes (PRI) (NACO, Link Worker Scheme and Operational Guidelines, 2009)."

2.2.2. Activities and outcomes of the project (Nov' 12 to Mar' 13)

2.2.2.1. The programme covers approximately 23,000 HRGs, 3,00,000 bridge population, 5,00,000 vulnerable people, 11,221 PLHIV and 3968 OVC. The programme has been instrumental in establishment of the below mentioned:

- 2500 Red Ribbon Clubs are functional.
- 2500 Village Information Centres are functional.
- A cadre of around 25000 volunteers developed and

S. N.	Indicators	Targets	Targets in numbers	Annual achievement in numbers	Annual achievement in %
1	Number of Link workers recruited and trained	40 per district	1000	922	92%
2	Number of DRP/ Training Officer recruited and trained	2 per district	50	46	92%
3	Number of Supervisors recruited and trained	4 per district	100	93	93%
4	No. of village volunteers recruited and trained	1000 per district	25000	29778	119%
5	Number of Village Information Centers (VIC) established	100 per district	2500	2434	97%
6	Number of Red Ribbon Clubs (RRC) formed among in community with regular events	100 per districts	2500	2435	97%
7	No of Condom Depots established (free distribution)	100 per district	2500	5938	238%
8	High Risk Individuals reached by link workers, village wise with information relevant to HIV prevention and risk reduction.	90% of mapped population	22217	25426	114%

9	Vulnerable young people reached by link workers, village wise with information relevant to HIV prevention and risk reduction.	90% of mapped population	763058	957002	125%
10	Percent of people from high risk groups referred by link worker/volunteers to HIV related services	90% of mapped population	22217	39946	180%
11	Testing and counselling : % of HRG who received HIV testing in the last 12 months and who know their results	70% of mapped population	22217	16680	75%
12	% of Vulnerable population Referred for ICTC testing	45 % of Mapped population	763058	872409	114%
13	Testing and counselling : % of Vulnerable population who received HIV testing in the last 12 months and who know their results	40% of Mapped population	763058	344050	45%

2.2.3. Lessons learnt (Nov' 12 to Mar' 13)

- Before KHPT took over, each district implementing organisation was using different monitoring and evaluation formats and back end documents. This was posing a difficulty in analyzing the data at state level and use the same for programmatic improvements. Some of those formats were also very complex in design and thus difficult to administer, for the field staff. KHPT has simplified and streamlined the M & E system of the project in Maharashtra.
- Though the programme was covering all the HRGs in the project area, it is necessary to track them not just as number but as an individual and specific services provided to them through the programme.
- Under the LWS programme, training budgets are provided only in the first 2 years of the programme. Since KHPT took over as a lead agency in its 4th year, no training budgets were allocated to KHPT. Due to this refresher trainings and

training of new recruited staff due to turn over was a challenge. KHPT conducted on site handholding trainings for District Resource Person (DRP), supervisors, link workers, M and E officer and accountant for all its partners during its field visits.

2.3. Sabala Project

2.3.1 Project Profile

2.3.1.1. Partners:

Evaluating partners: Social and Mathematical Epidemiology Group, London School of Hygiene and Tropical Medicine (LSHTM), and the Centre for Global Public Health (CGPH), University of Manitoba, Canada.

Implementing partners: Karnataka Health Promotion Trust, Department of State Educational Research and Training (DSERT), Karnataka, the Adolescent

2.3.2. Activities and outcomes

2.3.2.1. Funding:

- Efforts to sustain the levels of funding for this initiative were:
  - KHPT submitted a proposal to the World Bank (WB) to continue the work with adolescent girls in North Karnataka for next 2 years. The organization received positive response from WB.
  - KHPT responded to call of proposal from 3ie (for evaluation) in partnership with London School and UoM and was invited for full proposal.
  - KHPT also responded to call for proposals from McArthur Foundation. This was not successful.

2.3.2.2. Theory of Change (ToC)

- The project developed its Theory of Change with support from STRIVE program
  - The project discussed and facilitated debates within the team to develop the theory of change for the project with support from facilitators from London School of Hygiene and Tropical Medicine.
  - Sabala's Theory of Change was a response to the problem that many adolescent girls in northern Karnataka are vulnerable to HIV and suffer a diminished quality of life. Sabala's Theory of Change assumption was that if adolescent girls completed 10th standard they will marry or enter sex work late, this would in turn reduce their vulnerability to HIV and improve their quality of life.
  - Based on this assumption, the project designed interventions to work with various groups such as families, teachers and headmasters, School Development and Management Committee (SDMC) members, boys,

- community groups, local governing bodies, Department of Education officials and the media.

2.3.2.3. Research studies

- With the support of STRIVE the following studies were undertaken:
  - Enumeration of high schools and high school students in Bijapur and Bagalkot districts.
  - Enumeration of higher primary schools and adolescent girls who completed 7th standard was undertaken to establish baseline for the rates of enrolment.
  - A qualitative study to explore the factors that influence the retention and dropout of adolescent girls from educational institutions was undertaken in Northern Karnataka. This study was conducted in select villages of Bagalkot and Bijapur districts.
  - A feasibility study was conducted to assess the Parivartan model developed by International Centre for Research on Woman (ICRW), where sports were used as a medium to communicate the messages of gender, sexuality and vulnerabilities. As this model was implemented in an urban setting, a feasibility study was conducted in Sabala intervention districts-Bagalkot and Bijapur to test its relevance and applicability in rural context.

2.3.2.4. Assessment and intervention with adolescent girls

- A series of workshops were conducted with adolescent girls in North Karnataka to understand their lives, vulnerabilities and motivations.
  - 3 days residential workshop was conducted with 3 key sessions - self exploration, sharing of dreams and aspirations and creative expression. The participants included girls from 9 – 18 years. Most participants expressed the need to continue education and pursue a career.

2.3.2.5. Building capacities of the schools

- Efforts were made to develop separate training curriculum for training the teachers
  - The rationale behind this form of intervention was that the school teachers are in a position to influence the gender roles of their students, impact students' educational outcomes and can be a change agent to promote girl education and to reduce gender disparity. By training, the attitudes of the teachers can be influenced.
  - This curriculum included aspects like understanding of sex & gender - defining sex and gender, social construction of gender, working of gender as a system – gender stereotyping in schools, gender responsive schools, role of teachers in promoting gender equity in schools and so on.

- The curriculum was under review and the training of teachers was to be initiated.

2.3.2.6. Linkage with programs and entitlements

- Efforts were made to develop a manual on government programmes and schemes for adolescent girls.
  - The aim of the program has been to ensure significant rise in uptake of relevant government programs by girls and their families.
  - This was to be like a reference book, detailing out programmes and schemes and ways to access to the programs and also reflect as case studies of girls who have benefitted out of utilisation of the facilities.

2.3.2.7. Joining the girl child campaign, International day of Girl Child – 11th October 2012

- International Day of the Girl Child
  - 11th October 2012 was observed in the district of Bijapur and Bagalkot to celebrate the International Day of Girl Child to recognize rights that girls are fundamentally entitled to have and discuss about the unique challenges faced by girls from their childhood.
  - 56 adolescent girls from 8 villages were mobilized for this event in Bagalkot and 160 girls participated in Bijapur district.
  - Performances of skit about their rural area by the adolescent girls and sports events like lagori, tug of war and debates on importance of girl child education were organised.
  - This program was attended by key district government officials in Bagalkot and Bijapur districts from different government departments.

2.3.2.8 Staff capacity building activities

The staff underwent various capacity building activities. Details are as follows:

Table 2.2: Capacity building of the staff (Sabala project)

SL#	Date	Type of training
1	5th- 6th Sept' 2012	Orientation to outreach workers on high school survey.
2	11th - 12th Dec'2012	Orientation to staff on Parivartan Plus model on working with boys and adolescent girls.
3	19th - 20th Dec' 2012	Adolescent girls program review and planning workshop for staff members.
4	13th Mar' 2013	One day orientation for field staff on high school and feeder school survey formats.

2.3.3. Publications

- Mallika B, Mohan HL, Soni S, Raghavendra T. (2012) Know me: A self-exploratory exercise to understand vulnerabilities of adolescent girls – A northern Karnataka experience. Bangalore, India, KHPT.http://strive.lshtm.ac.uk/resources/knowme-understanding-vulnerabilitiesadolescent-girls

2.3.4. Challenges

- Securing government participation and buy-in were crucial for the successful programme implementation. The government approval was required for interventions with schools and children and for collection of data and information. The program collaborated with district governments in Bagalkot and Bijapur
- right from the start of these interventions. For instance in Bagalkot district, the rapport with the District Commissioner's office was beneficial in securing government funding, and receiving support from other departments and Civil Society Organizations (CSOs). It also helped to accelerate the process of creating linkages with other government departments (for e.g. Department of Social Welfare) whose programmes will aid Sabala's interventions in future.

2.3.5. Lessons learnt

- The fact that the headmasters and teachers were enthusiastic could be used as an opportunity to include them in the planning stage itself when the details of the activities are charted out.
- In some schools where the teachers were motivated a pilot tracking tool could be developed.
- During the training of SDMC members, it would be important to include a session on what are the consequences of drop outs and how the issue affects the whole community. Gender analysis of the issue needs to be done along with the members and the reasons for girl child drop out should be understood in relation to gender norms and practices including stereotypes.
- Training of the teachers
  - The gender training planned for teachers need to be practical and should also have an action plan.
  - It would be better to train all staff of the school rather than selected teachers on gender.
  - The project should position itself to support the teachers in follow up where the teachers find it challenging.

2.4. Sampoorna- LWS KSAPS

2.4.1 Project Profile

2.4.1.1. Partners:

NACO, State AIDS Control Society (SACS), KHPT, District AIDS Prevention and Control Units (DAPCU).

Implementing partners: Christian Council for Rural Development and Research (CCCOORR), Chaitanya Rural Development Society, Samuha, Institute for Youth and Development.

2.4.1.2. Funders:

NACO-GFATM Round VII

2.4.1.3. Duration

Sep'2009- Oct'2013

2.4.1.4. Area of work:

- Karnataka: Uttar Kannada, Gadag, Haveri, Shimoga, Kolar, Chitradurga, Dakshin Kannada, Bangalore Rural.

2.4.1.5. Target Community:

High risk groups, vulnerable populations and people living with HIV in 100 priority villages in each district.

2.4.1.6. Goal of the project:

The project's overall goal is to develop a comprehensive rural program that provides HIV and AIDS prevention, care and support to at risk and vulnerable populations in 8 A category districts in Karnataka.

2.4.1.7. Objectives of the project:

"Reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction."
This entails:

- "Increasing the availability and use of condoms among HRGs and other vulnerable menand women.
- Establishing referral and follow-up linkages for various services including treatment
- forSTIs, testing and treatment for TB, ICTC/PPTCT services, HIV care and support services including ART.
- Creating an enabling environment for PLHA and their families, reducing stigma

- anddiscrimination against them through interactions with existing community structures/groups, e.g. Village Health Committees (VHC) , Self Help Groups (SHG) and PanchayatiRaj Institutes (PRI) (NACO, Link Worker Scheme and Operational Guidelines, 2009)."

2.4.1.8. Background of the project

Karnataka Health Promotion Trust (KHPT) is a lead agency for implementation of Link Workers Scheme in 8 districts under GFATM Round 7 in Karnataka. The implementation of the scheme is being carried out in a phased manner. In 2008-09, the scheme was being implemented in 2 districts i.e. Uttar Kannada and Shimoga. The scheme was implemented in 6 more districts i.e., Bangalore Rural, Chitradurga, Dakshina Kannada, Gadag, Haveri and Kolar. 100 villages have been shortlisted and selected for implementation of Sampoorna in each district. The project also envisages the facilitation of community members to develop ownership and sustain the scheme beyond the life of the programme through Formation of youth groups, red ribbon clubs and involvement of about 1000 volunteers per district (Our projects).

2.4.2. Activities and outcomes:

During the reporting period, the LWS project managed to implement the LWS in line with operational guidelines with support of DAPCU and Karnataka State AIDS Prevention Society (KSAPS). Major achievements of LWS-NACO-KSAPS were as follows:

2.4.2.1. Work with District Implementing Agencies (DIA)

- Lead agency planned and conducted number of refresher trainings for District Implementing Agencies (DIA) staff and ensured rollout to link workers in all the 8 intervention districts.
- Theme based mid-media plan was developed and shared with DIAs.
- Information Education and Communication (IEC) materials recommended by NACO were adopted and shared with DIAs.
- Joint review of District Implementing Agencies (NGOs) was conducted on 19th Jul'2012 and 27th and 28th Feb' 2013 with participation of lead agency and SACS.
- As the implementing partner withdrew from the project, a new DIA was selected in Chitradurga with effect from May' 2012 which resulted in improved performance in the last three months.

2.4.2.2. Learning sites

- Bangalore Rural District was identified as a Learning Site. A concept note with a detailed capacity building plans was developed. Three levels of trainings were conducted.

2.4.2.3. Program to strengthen community structures

- Community Structures Strengthening Programme scaled up to all the intervention districts, and ensured participation and ownership building of community groups in planning and implementation of programme activities.

2.4.3. Achievements

Table 2.3: Achievements against milestone indicators (Sampoorna project)

Indicator	Target	Achievements
No. of districts' implementing LWS	8	8
Total no. of DRPs recruited	16	16
No. of Link Workers recruited (40 per district)	320	284
Number of Supervisors recruited and trained	32	32
No. of HRGs covered	90%	101%
No. of vulnerable population covered	90%	106%
No. of HRGs referred to ICTC	90%	100%
No. of HRGs tested for HIV	70%	86%
No. of HRGs tested for STI	70%	88%
No. of village information centres formed	800	1478
No. of red ribbon clubs formed	800	1438
No. of condom depots established	1600	1697
No. of village volunteers recruited and trained	8000	14099

2.4.4. Lessons learnt

- Trainings/workshops to strengthen community structures served as good initiatives in all the districts. This had helped to garner good support for the LWS activities in the villages.
- Red Ribbon Clubs (RRC) and volunteer involvement in the program was improved in all the districts. In most of districts, RRCs had been linked to Nehru Yuvak Kendra.
- Community Structures like SHGs, RRCs, caste and faith based groups and youth associations took initiative to conduct many awareness programs in the villages. Youth focused activities had encouraged participation of youth in project activities. With time community ownership had increased in these programs.

- The convergence with government health system was improved considerably. This improved access to STIs/ICTC testing services in the villages.
- Micro monitoring tool that was developed and implemented at the district to sub cluster level, had improved program performance and facilitated supportive supervision and monitoring at all levels.
- Best practices were identified and five abstracts were sent to NACO conference held in April 2012.
- Addressing non-HIV community helped to sustain the good rapport of the project with the community.
- A good linkage at community level helps the project to render services easily and provided recognition for the project and its staff in the villages.

2.5. Samvedana

2.5.1 Project Profile

2.5.1.1. Partners

KHPT, Community Based Organizations, Centre for Research and Advocacy (CFAR), National Law School of India University (NLSIU), Karnataka Judicial Academy(KJA), National Institute of Mental Health and Neuro Sciences(NIMHANS).

Implementing partners: The implementing partners are 16 CBOs in 15 districts of Karnataka. Aids Jagruthi Mahila Sangh, Bijapur; Beladingalu Mahila Okkuta, Raichur; Belaku Mahila Sangha, Dharwad; Chaitanya AIDS Prevention Women's Sangh, Bagalkot; Durga Shakthi AIDS Thadegattuva Sangha, Davangare; Jeevan Jyothi Mahila Abhiruddhi Samasthe Gulbarga; Ondu Gudu Mahila Sangha, Tumkur; Raksahane Jilla Mahilaa Okkoota, Gadag; Sadhana AIDS thadegattuva Mahila Sangha, Shimoga; Shakthi Aids Tadegattuva Mahila Sangha, Gokak; Soukhya Samrudhi Samsthe, Kolar; Soukhya Sanje Samasthe, Chickballapur; Soukya Belaku Samudaya Seva Samsthe, Bellary; Soukya Samudhaya Samsthe, Chitradurga; Swathi Mahila Sangha, Bangalore Vijaya Mahila Sangha, Bangalore.

2.5.1.2. Funders

United Nations Trust Fund

2.5.1.3. Duration

Dec'11- Nov'14

2.5.1.4. Area of work

Karnataka

- Intensive intervention districts: Gulburga, Bijapur, Raichur, Bagalkot, Belgaum, Gadag, Dharwad, Bellary, Chitradurga, Davangere, Shimoga, Tumkur, Chickballapur, Kolar, Bangalore urban.

- Non- intensive intervention districts: Bidar, Chamarajnagar, Charajnagar, Dakshin Kannada, Hassan, Haveri, Kodagu, Mandya, Koppal Ramnagara, Uttar Kannada, Udupi, Yadgir, Bangalore Rural.

2.5.1.5. Target Community

FSWs in Karnataka

2.5.1.6. Goal of the project

Inclusive society free from Violence Against Women (VAW) in sex work.

2.5.1.7. Objectives of the project:

- To create awareness on the issues of violence and its interface with HIV among the
  - Women in sex work
  - Intimate partners
  - Families of the community members
  - Service providers
- To improve access to affordable, quality services (health, legal, justice, protection, police, etc) free from stigma and discrimination for the women in need.
- To increase coordination amongst and within civil society, CBOs and government entities working to address the intersection of VAW and HIV to meet project objectives.

2.5.1.8. Background of the project

Women in sex work, in Karnataka, as elsewhere, are doubly marginalised as they routinely experience violence in their private and public lives as a manifestation of the stigma and discrimination attached to them as poor, uneducated, "low" caste women, and as "immoral" sex workers. The project considers violence as a human rights issue and will also address the interface of Violence Against Women (VAW) and HIV. The women in sex work may experience physical and sexual violence from their intimate partners as well as other forms of violence from clients, pimps, madams and the police.

2.5.2. Activities and outcomes

2.5.2.1. Development of modules:

- As part of the project activity to develop modules to train the trainers and facilitators on violence against women, HIV and its interface with sex work, 15 training modules were proposed. 7 training modules were developed where women from community also participated. The work on the remaining 8 modules was in progress. The modules topics were like

- fundamental rights, perception of violence, safety plans to combat for VAW, create an understanding of the domestic violence law, police- Immoral Traffic Prevention Act (ITPA) and Karnataka Police (Nuisance) Act, what are the things to do when one gets arrested, personal laws- marriage act, importance of will writing, saving & credits (interest rates), communication skills – negotiations & assertiveness, property rights / tenancy laws, influence of violence on children and protection, divorce, maintenance, custody of children, services – legal cell, Women and Child Development, hostels for children facing stigma and discrimination.
- Module for the police training was developed in consultation with Gender Sensitization and People Friendly Police Project (GSPP) and consultants.
- The Judiciary training module was also finalised and rolled out with support from NLSIU.
- Counselling training module was also developed with NIMHANS.

2.5.2.2. Training of the staff

- Induction training of district staff:
  - Perspective building training for the Advocacy Coordinators and District Project Coordinators (AC/ DPC) was organized on gender and violence related topics, project details, documentation and reporting from 24th Jul to 26th Jul'2012. 36 participants (22 males; 14 females) attended this training.
- Training for project staff on formats and CBO assessment:
  - Training for DPC/AC on monthly reporting, violence card and assessment of Support Groups/Self Help Groups (SG/SHG) based on the format was organised to orient the staff. The training had 34 participants (21 males; 13 females).

2.5.2.3. Training of stakeholders

- Santwana and Targeted Intervention (TI) workers:
  - Training for Santwana and Target Intervention workers was organised in coordination with NIMHANS from 25th to 27th Sept'2012. The objectives of the training was to provide an understanding of the types of violence faced by women in sex work, and also clarify interface of violence and mental health and to build skills of counselling women who are currently facing violence. The number of participants was 19 (19 females) for the training.
  - TOT counseling training was organized from 18th Dec to 22nd Dec' 2012 at NIMHANS. The resource persons for the trainings were from KHPT and NIMHANS with participation from psychology post graduate students and a training consultant. The training was attended by 12 participants (8 females; 4 males).

- Work with Medical doctors :
  - 6 doctors were sensitized on violence faced by women in sex work, types of violence faced, consequences and manifestations of violence faced by FSW, assessing the violence when FSWs seek medical service. There were two doctors working as private practitioners and 4 of them were working as government doctors. The program was organised in Feb and Apr' 2013 and the venue was Vijay Mahila Sangha (VMS) CBO in Bangalore.
- Modular training
  - The modular trainings were planned in two batches- Batch 1(7 Modules) and Batch 2(8 modules). The training during the reporting period was done in cascading fashion.
  - Modular training (Batch 1) was organised at the state level (table 2.4). The participants for state master training were from DEEDS organisation and the resource persons were from KHPT. The objectives of state masters training was to build perspectives on female sex workers, roles and responsibilities of state master trainers and training on the 7 modules.
  - Modular trainings (Batch 1) for district master trainers was organised where the participants of the state master trainings took sessions for the district master trainings. The sessions for district masters training were on orientation on project Samvedana, support group functioning, training methodology and adult learning principles, sessions on the 7 modules, mock sessions, etc. The modular training for batch 1 for state and district master trainers was completed by Nov' 2012.

Table 2.4: Modular Trainings (Batch 1) for state and district level (Samvedana project)

Sno	Training	Dates	Location	Number of participants
1	Modular Training Batch1(7 Modules) state masters training	16th Oct-19th Oct' 2012	Vidya Deep College, Bangalore	25 participants (females)
2	Modular Training Batch 1(7 Modules) district masters training	29th Oct - 3rd Nov'2012	Vidya Deep College, Bangalore	77 participants (45 females and 32 males).
3	Modular Training Batch1(7 Modules) districts masters training	5th Nov' to 10th Nov' 2012	Tapovana, Davangere	82 participants (26 males and 56 females).

- The next level of training for batch 1 was Support Group Facilitator's trainings. These trainings were organised in districts of North and South Karnataka. More than 50 trainings were organised during Nov'12 to Mar'13. The trainings had objectives to train the participants for conducting the 7 module trainings to the SHG/SG members, enhance the knowledge of the facilitators and prepare action plan for the further rollout.
- Modular trainings (Batch 1) at the field level were organised with participation from more than 103000 women.

- Judiciary trainings:

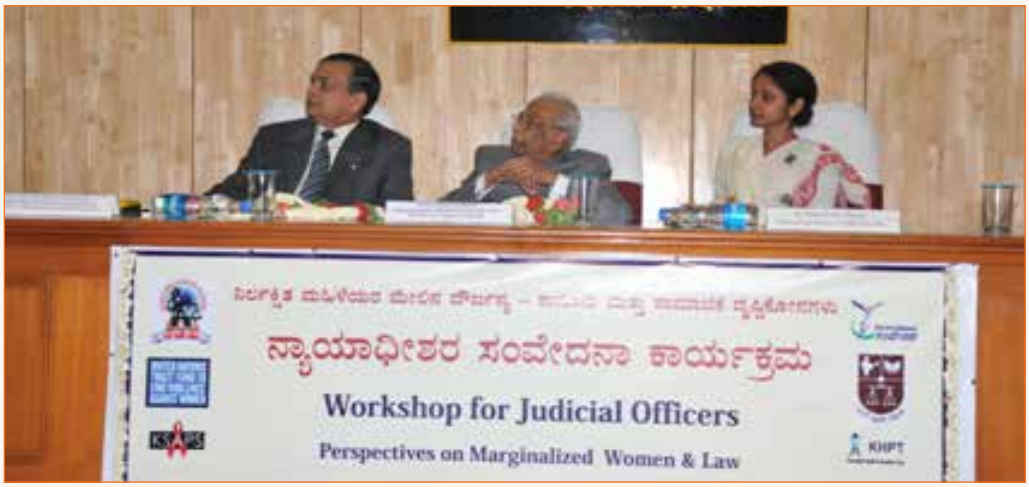


Photo 2.3: Guests at the Inaugural of Judiciary training from Left to Right: speech by Mr. V.S.Malimath, chairman, Karnataka State Law Commission, Mr. N.Kumar, Judge High Court, Dr. Sarasu Thomas, assistant professor, NLSIU, 3rd – 4th Nov' 12

- Trainings for the Judiciary were organised with Karnataka Judicial Academy (KJA) and National Law School of India University (NLSIU), Bangalore. KHPT got cooperation from the KJA.
- The trainings were organised with the objective to disseminate information on HIV scenario in the state and its implications – social, developmental, economic, familial; to create awareness among Judiciary on the issues of the community women; to provide an understanding and sensitize participants on the issues of sex work and its determinants (risk and vulnerability) & its implications (social, psychological, economic, familial); to provide an in-depth understanding about the dimensions of violence against women in sex work & their perpetrators; to provide an understanding about gender, sex & sexuality; to provide an understanding about laws relating to trafficking, sexual exploitation, domestic violence & other laws that concern women; to share evidences of violence against women and the interface of law and to discuss the role of judiciary in ending violence against women in sex work.

- The resource persons were from KHPT, NLSIU, GSPP and other consultants.
- The inaugural was organised on 3rd – 4th Nov'2012, where Mr. V.S. Malimath, Chairman of Karnataka State Law Commission, N. Kumar, Judge, Karnataka High Court, Dr. Srinath Maddur, Director, KHPT, Dr. Sarasu Thomas, Assistant Professor, National Law School of India University (NLSIU), Mr. Ashokanand, Director, KHPT were guests.
- Some of the trainings were reported newspapers like Vijay Karnataka, Kannada Prabha, The Hindu and Deccan Herald. The trainings were also reported on the web by Times of India, the New Indian Express, Times of India (Mysore). The inaugural speeches by Hon. Justice N Kumar and Justice V.N. Malimath were included in Karnataka Judicial Academy website www.kjablr.kar.nic.in.
- Training of Trainers was organised from 6th Feb to 8th Feb'13 at the Judicial Academy where faculties from law colleges in Karnataka participated.
- The feedback form took inputs from the participants on liking for the training, what they did not like in the training, comments and suggestions to improve the training.

Table 2.6: Police Trainings (Samvedana project)

Sno	Training	Dates	Location	Number of participants
1	Police TOT	5th- 6th Oct' 2012	Karnataka Regional Organisation for Social Service, Bangalore	11 participants (9 males, 2 females)
2	Police sensitisation	10th -11th Oct' 2012	Superintendent Office, Koppal	31 participants (30 males, 1 female)
3	Police sensitisation	12th Oct' 2012	Police Training College, Nagenahalli, Gulbarga	595 participants (595 male)
4	Police sensitisation	30th Oct' 2012	Police Training School, Bijapur	150 participants (150 males)

- Media sensitisation workshop:
  - Sensitization workshop was organized at Chitradurga on 9th Jan' 2013 at the Conference Hall, Hotel Aishwarya Fort.
  - The workshop was well-attended. 27 persons attended the programme, including 5 from visual media. The president of District Working Journalists Union and a retired senior journalist from The Times of India were also participants of the workshop. The women shared their experiences in front of the participants.

- Crisis Management Team training on reporting format:
  - The Crisis Management Team (CMT) members at the districts were given orientation on Project Samvedana, violence reporting and documentation. The training included topics on monthly report format, training report format, outreach report format (pink card), Form K violence consolidation format and Behaviour Tracking Survey.
  - The trainings were organised in 15 districts of North and South Karnataka.

2.5.2.4. Campaigns:

- Campaigns were organized in the districts of Karnataka under the project's objective to increase coordination amongst civil society, Community Based Organizations (CBOs) and government entities. The campaigns were organized in partnership with Centre For Advocacy and Research (CFAR).
  - The campaign preparation included meeting officials from the government offices like Department of Women and Child Development at the districts, police, judiciary, media and NGOs. Preparation also included meetings with the community women. The campaigns were organised by district staff, CBOs and KHPT staff.
  - The campaigns also included a rally with participation from community women and staff. Memorandums were presented to the government officials in districts with topics like social entitlement, old age
  - pension, reservation for women, ration card, voter id, etc.
  - Officials from government departments like the Police, Judiciary, Women and Child Department, Social Welfare Department, Civil Society Organizations (CSOs) and members from CBOs were invited as guests. The guest delivered speeches on issues like social entitlements, police response, brief on Samvedana project, suggestions such as alternate employment, etc.
  - Post campaign work included meetings with the government officials of the different/various departments.
  - Campaigns were covered by print and electronic media.

Table 2.7: Campaign dates (Samvedana project)

Campaigns	Date
Kolar	18th Oct'12
Davangere	2nd Oct'12
Bangalore Urban	22nd Nov'12
Shimoga	25th Nov'12

Raichur	17th Jan'12
Bijapur	17th Jan'12
Gadag	3rd Feb'13
C'drga	15th Feb'13
Dharwad	20th Mar' 13
Chickballapur	26th Mar'13

- The FSW CBOs of Gadag, Bangalore Urban & Raichur participated in the "One Billion Rising" campaign at Bangalore and also conducted the same in districts

2.5.2.5. Format developed:

- To track the number of advocacy efforts for the referred services and linkages by the Samvedana and Target Intervention staff, the project developed an Advocacy Tracking sheet.

2.5.2.6. Support Group/Site group formation/SHG:

- The number of support group/site groups/SHG in the districts were 794(Sept), 993(Oct); 647(Nov); 817(Dec); 1011(Jan); 1158(Feb); 1207(March).

2.5.2.7. Crisis Management teams and crisis response:

- Strengthening of the Crisis Management Teams(CMT):
  - Work was undertaken on strengthening crisis management teams at the district and taluk level.
  - Meetings were organised to discuss about violence faced and reported by the women in sex work during the month, the measures taken, advocacy efforts, etc.
  - The teams worked with the KSAPS.
- Case reporting, response and referral:
  - Total number of cases reported during the months of Sept'12-Mar'13 was 2603.
  - Approximately, 80% of the cases were given a response within 24 hours.
  - The women were referred to different services such as STI services, HIV testing and counselling, counselling, legal aid, social entitlements, short stay homes, police, hospitals and other services.The work of crisis intervention was undertaken with KSAPS.

2.5.3. Challenges

- Working with the primary and secondary stakeholders in a limited time frame was a challenge.

- Structured efforts were required towards integration of community and stakeholders at the ground level.
- Follow up with the judiciary and police after sensitisation had been a challenge, due to transfer and their schedules.
- Issues like violence against women and HIV would require more intensive efforts over a longer period of time.
- Progress for the in service police training was not as expected.

2.5.4. Lessons learnt

- Coordination with the Karnataka Judicial Academy and National Law School of India University, Bangalore supported in organising Judiciary training.
- Identifying and involvement of the key officials in the government departments who were interested and empathetic towards the issue of violence against women in sex work facilitated in the implementation of the project.
- The campaigns were conducted in different districts and had pro active participation from government departments like health, judiciary, police, Department of Woman and Child Development, social welfare department, Civil Society Organizations (CSOs) and CBOs. Thus, the campaigns provided a platform for the involvement of government officials and awareness generation among the community women and larger society on the violence issue faced by women. The media covered this whole event to sensitize the larger society.
- Involvement of community in the development of modules provided a platform for community participation.

Photo 2.4: Rally as part of the campaign at the district level (Raichur),17th Jan, 2012

2.6 Samvedana Plus project

2.6.1 Project Profile

2.6.1.1. Partners:

Implementing partners: CBOs of FSWs Chaitanya AIDS Thadegattuva Mahila Sangha in Bagalkot district and AIDS Jagruthi Mahila Sangha in Bijapur district.
Evaluating partners: Social and Mathematical Epidemiology Group, London School of Hygiene and Tropical Medicine (LSHTM), and the Centre for Global Public Health (CGPH), University of Manitoba, Canada.

2.6.1.2. Funders

Bill and Melinda Gates Foundation and United Nations Trust Fund to End Violence Against Women (UNTFEVAW)

2.6.1.3. Duration:

Apr 2013- 2016

2.6.1.4. Areas of intervention

Jamkhandi and Mudhol talukas of Bagalkot district and Bijapur and Bagewadi talukas of Bijapur district.

2.6.1.5. Target Community

Community women, Non-Paying Intimate Partners

2.6.1.6. Goal of the project

Reducing risk and vulnerability of sex workers to partner violence and STI/HIV transmission in intimate partnerships.

2.6.1.7. Objectives of the project

Samvedana plus was designed to pilot a model in which the interventions and evaluation regarding Intimate Partner Violence (IPV) and HIV risk will deepen KHPT and CBO's evidence base, ongoing work and enable advocacy on gender-basedviolence against FSWs in the context of HIV.
The long term outcomes for the project are

- Increased individual and collective processes and actions to reduce intimate partner violence and STI/HIV risk.
- Enhanced STI/HIV risk perception and skills for self protection among FSWs and their intimate partners.
- Improved supportive environment for dialogue and action on intimate partner violence.

2.6.1.8. Background of the project

According to a study by Beattie et al, "Participants in the IBBAs reported the main perpetrators of violence as clients (56.2%), regular partners (22.8%), "rowdies" (6.9%), the police (6.6%) and pimps (3.0%)(Beattie, et al., 2010)." Violence impacts adversely on condom usage and access to HIV services for female sex workers (FSWs).

2.6.2. Activities and outcomes

2.6.2.1. A series of consultations were held with the stakeholders like Joint Director, Targeted Interventions (TI), and Project Director, KSAPS and the Health Secretary of the Government of Karnataka to influence policy and scale up of the interventions and to take their support. Discussions were held on ways in which the intervention will help address this issue, thereby contributing to lessening the prevalence of HIV in the community. These sessions helped to convincingly put forth a broader perspective of violence against FSWs, which in addition to police aggression, included violence from intimate partner, family members, media, and judiciary. Till now, state support to the TIs on the issue of violence was limited to provision of budgets for the formation and strengthening of crisis management teams which mainly responded to cases of police violence. However, the advocacy efforts have resulted in the following outcomes:

- Inclusion of intimate partner violence as an indicator, for non-usage of condoms by female sex workers, in the monitoring and evaluation framework of KSAPS TI programmes for the year 2013-2014.
- Inclusion of condom use with intimate partners as a priority intervention strategy within the KSAPS TI programmes for prevention and control of HIV/AIDS.
- Integration of violence reporting format, the 'pink card', as part of the KSAPS TI programmes. The peer workers, as part of their regular visits, use this card to document information about the perpetrators of violence and type of violence faced by the FSWs. This is a significant departure from using Form K of NACO's M and E format which records only the number of incidents of violence reported. The pink card is not part of the NACO strategy and is an innovation approved by KSAPS as a result of advocacy by KHPT. This has been in use since Oct' 2012, and has significantly improved violence reporting.

2.6.3. Publications

- Shaw S and Pillai P. (2012) Understanding risk for HIV/STI transmission and acquisition within non-paying partnerships of female sex workers in Southern India; Bangalore, India, KHPT http://strive.lshtm.ac.uk/resources/understanding-risk-hivsti-transmission-andacquisition-within-non-payingpartnerships.

- Pillai P, Bhattacharjee P, Ramesh BM, Isac S. (2012) Impact of two vulnerability reduction strategies – collectivisation and participation in savings activities – on HIV risk reduction among female sex workers; Bangalore, India, KHPT http://strive.lshtm.ac.uk/resources/impact-two-vulnerability-reduction-strategieshiv-risk-reduction-among-female-sexworkers.
- Pillai P, Bhattacharjee P, Raghavendra T. (2012) Understanding stigma together: workshop with sex workers on HIV-related stigma and discrimination, Bangalore, India, KHPT, http://strive.lshtm.ac.uk/resources/understanding-stigma-together-workshop-sex-workers.
- Andrea K Blanchard, Haranahalli Lakkappa Mohan, Maryam Shahmanesh, Ravi Prakash, Shajy Isac, Banadakoppa Manjappa Ramesh, Parinita Bhattacharjee, Vandana Gurnani, Stephen Moses, James F Blanchard (2013); Community mobilization, empowerment and HIV prevention among female sex workers in south India; BMC Public Health 2013,13:234.
- A blog post "Sex work, violence and HIV: experience from rural Karnataka" by Parinita Bhattacharjee [http://www.opendemocracy.net/5050/parinita-bhattacharjee/sex-work-violence-and-hiv-experience-from-rural-karnataka] was featured in the web journal, 'Open Democracy'. The blog discussed the existence and severity of intimate partner violence faced by FSWs, the adverse effect of violence on their condom usage and uptake of clinical services, and the need to address the broader structural factors of violence for effective HIV prevention. It talks about KHPT's partnership with the STRIVE consortium and district level sex worker CBOs to empower FSWs to address violence in their intimate partnerships.

2.6.4. Challenges

- Group reflective process for intimate partners was not conducted this year after the first trial of four sessions. A need for different module was observed. The action taken involved searching for modules over the internet and developing some modules and that would be reviewed by gender and law experts.
- It was planned to organize community events like folk shows and street plays to have a discussion on issues of VAW and IPV. But this was not organized this year. The action taken included initiating discussions with other teams of folk group. We hope to implement some of these community events in the next two quarters.

2.6.5. Lessons learnt:

- For reduction in violence, work should be undertaken with both victims and perpetrators of violence and other stakeholders.

- Immediate support to community women will help protect them from future violence.
- With better skills (negotiation, communication) and greater access to female condoms FSWs will be able to negotiate safe sex with IP.
- Individual and collective action against violence and/or STI/HIV transmission requires a supporting enabling environment.
- Building capacities of CBOs and linking them with women's organization would strengthen the support structure.

2.7. Sankalp- Phase II Post Transition Support

2.7.1 Project Profile

2.7.1.1. Partners:

Implementing partners: Basava Seva Trust (BST), Citizens Alliance for Rural Development and Training Society (CARDTS), Society for People Action for Development (SPAD), Belgaum Integrated Rural Development Society, Samraksha, Payana, CBOs.

2.7.1.2. Funders: Bill and Melinda Gates Foundation (BMGF)

2.7.1.3. Duration: Apr'2012-Mar'2013

2.7.1.4. Areas of intervention:

Bidar, Gulbarga, Yadgir, Bijapur, Raichur, Gadag, Bagalkot, Belgaum, Uttar Kannada, Dharwad, Haveri, Koppal, Bellary, Chitradurga, Davangere, Shimoga, Udupi, Dakshin Kannada, Chickmagalur, Tumkur, Hasana, Ramnagara, Bangalore rural, Bangalore urban, Chickballapur, Kolar, Chamrajnagar.

2.7.1.5. Target community:

FSW, MSM- Transgender

2.7.1.6. Goal of the project:

To improve the functionality of CBOs to address the issues of risk and vulnerability and to support CBOs in managing Targeted Intervention.

2.7.1.7. Objectives of the project:

KHPT's key objectives of the Post Transition Support (PTS) for the year 2012-13, as requested by KSAPS were:

- To provide program management support to KSAPS.
- To provide CBO institutional strengthening support under the community mobilization process across all the districts in Karnataka.

- To enhance cross learning across the state by documenting and disseminating best practices.
- To provide support in conducting outcome assessments.
- To continue supporting PPP ICTCs in Targeted Intervention (TI).

2.7.1.8. Background of the project:

KHPT handed over 7% of the TIs (Kolar, Chickballapur and Raichur) to SACS in the year 2009-2010.

- As per the Memorandum of Understanding (MoU) between NACO and Avahan, there was no transition done in the year 2010-11.
- In the year 2011-12, 20% of the TIs were transitioned i.e. across 6 districts (Chitradurga, Davangere, Shimoga, Uttara Kannada, Haveri and Gadag). 6 district TIs were handed over to KSAPS which later became 15 CBO led TIs under KSAPS funding.
- A clear list of activities was agreed upon in consultation with NACO & SACS/ Technical Support Unit (TSU) for post transition related activities focusing on programme support, community mobilization and facilitating sharing forums. KHPT also provided post transition support to 20% transition TI in the areas of institutional strengthening, crisis management and strengthening of support groups. These areas of support were finalized in consultation with KSAPS.

2.7.2. Activities and outcomes

2.7.2.1. Program Management Support:

- KHPT deputed 4 Senior Program Officers and one Medical Programme Officer to KSAPS office from June, 2012. These Program Officers reported to Joint Director (JD)-TI.
- The role of the officers was to support all KHPT districts transitioned to KSAPS during the year 2012-13, as per the NACO approved terms of reference of a TSU-Programme Officer (PO). They worked with the SACS TI team and coordinated community mobilization and program related activities in selected districts.
- Need based support was provided to KSAPS. KHPT recruited, trained and supported technical consultants for HIV care, treatment and support.

2.7.2.2. Community mobilization support and institutional strengthening

- Support was provided for institutional strengthening processes in CBO led TIs with focus on project management and maintenance of necessary documents and statutory compliances; community mobilization programme in NGO lead TIs; strengthening grass-root level groups, sub-committees, taluk & district level committees and structures based on the principle of democracy in CBOs and handhold CBO led TIs to utilize the Community Mobilisation budget effectively.

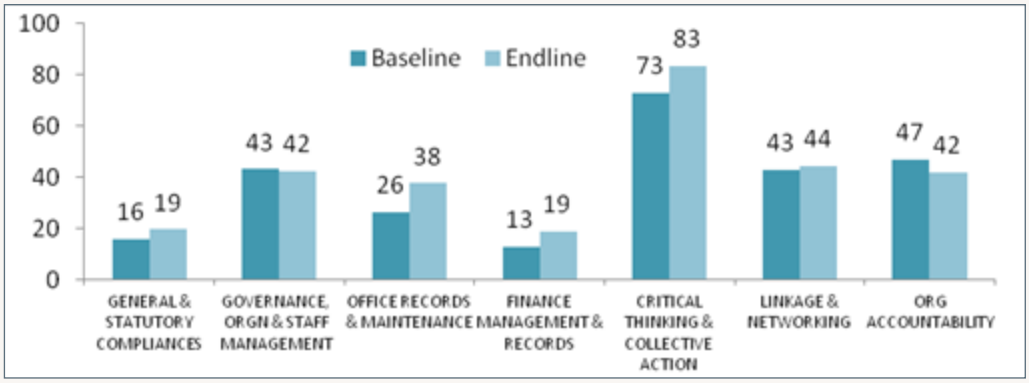
- A total of 26 districts were selected for the community mobilization program for FSW and MSM communities in Karnataka state. 59 FSW TIs and 33 MSM TIs were being implemented in 26 districts out of which 31 FSW TIs and 12 MSM TIs were CBO led.
- A separate grant agreement was signed with Payana-Sarathya for the year 2012-13 to strengthen the MSM CBOs in the five non-Pehchaan districts such as Shimoga, Davanagere, Chitradurga, Bidar and Kolar. Payana-Sarathya team would also support networking and advocacy program for MSM-T communities of the entire state. Since Shimoga and Davanagere were added to the Pehchaan district list, planned activities under Post Transition Support (PTS) for these districts were to be carried up to Mar' 2013.

2.7.2.3. Community Mobilization Planning and CBO assessment

- Prior to preparing a detailed action plan for the year 2012-13, a detailed CBO base line assessment was conducted to understand the status and the capacity building needs of the each of the CBOs. In total 22 FSW CBOs, 8 NGO led TIs and 3 non Pehchaan MSM CBOs were covered during the beginning of the year. Two rounds of assessment were conducted as base line in the beginning of the year and end line in the end of the year to measure the development of CBOs in Governance and Management aspects. A set of 155 questions related to 35 indicators were finalized in consultation with KSAPS. This was done both for the FSW and MSM CBOs. The results can be seen in the graphs below:

FSW CBOs

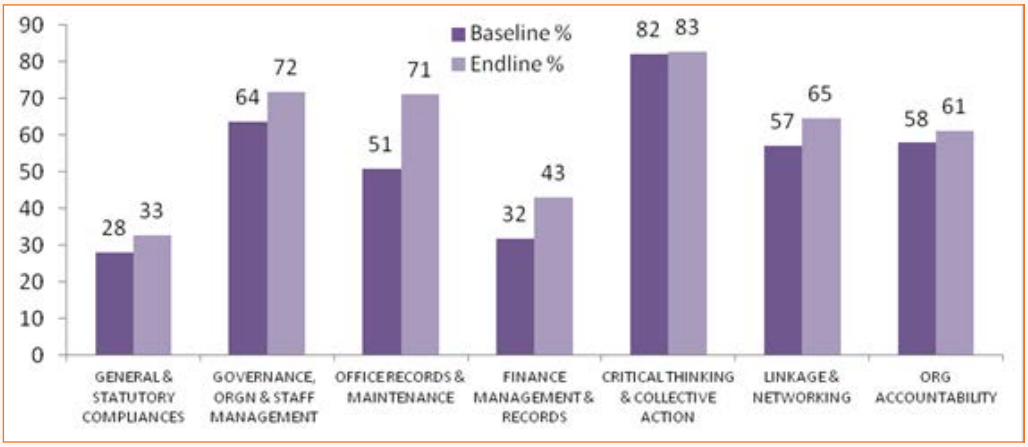
Figure 2.2: Baseline and end line comparison of CBOs (FSW)



MSM CBOs

- On request by few MSM CBOs, KHPT conducted a few need based capacity building exercises around the topics of perspective building, addressing violence and institution building. Formally, however, `Pehchaan' project was responsible for conducting capacity building trainings in its 19 CBOs. The baseline and end line was conducted in all the MSM CBOs of the state which included both the Pehchaan and KHPT districts. The findings and comparison of both base line and end line assessments are depicted in the below graph.

Figure 2.3: Baseline and endline comparision of CBOs (MSM)



2.7.2.4. Training Status

After base line assessment the resource team along with the Programme Officers had a discussion with the CBOs and prepared an action plan for the current year and drew timelines. Under the PTS programme, the following support strategies were planned and implemented for the districts:

- Training programmes: To strengthen CBO led TIs the following training programmes were conducted:
  a. Organizational Development (OD) and good governance of CBOs.
  b. Strengthening of committees on thematic subjects like advocacy.
  c. Perception building for the new CBO members.
  d. Training on advocacy for obtaining social entitlements and schemes from the govt.
  e. Systematic addressal of crisis management at various levels.
- Status of Training completed: With the help of POs of TSU and other concerned organizations, the PTS team was able to complete 94% of the trainings against the proposed batches of trainings for the CBO members and community staff.

Table 2.8: Status of the training programs

Subject	Proposed	Achieved	Balance	% achievement
Total Batches trained	707	665	42	94
Total Participants	18391	15608	2783	85
# of participants per batch	26	23	67	90

Details of the subject-wise training programmes conducted with CBOs during the reporting period are below:

Table 2.9: Subject wise training programs

Training Topics	Batches & participant	Trainings Proposed	Trainings Conducted	Trainings Balance	% Achievement
Perception Building	Batches	46	49	-3	107
	Participants	1460	1517	-57	104
Conscientisation workshop	Batches	13	8	5	62
	Participants	400	238	162	60
Organisation Development (OD) training	Batches	28	29	-1	104
	Participants	783	762	21	97
Taluk committees training	Batches	58	123	-65	211
	Participants	1874	3293	-1419	176
Sub committees training	Batches	54	49	5	90
	Participants	1637	1493	144	91
Statutory obligations	Batches	7	4	3	57
	Participants	160	82	78	51
Good Governance	Batches	15	12	3	80
	Participants	405	371	34	92
Finance Management	Batches	19	15	4	79
	Participants	440	385	55	88
Advocacy for Social Entitlement	Batches	26	13	13	50
	Participants	810	393	417	49
Human Resource Development (HRD) training	Batches	13	10	3	77
	Participants	225	257	-32	114
SG training	Batches	59	29	30	49
	Participants	1980	879	1101	44
Board of Directors (BoD) Meetings	Batches	262	256	6	98
	Participants	4682	3842	840	82
Promotion of Savings (Bank A/C, SHGs)	Batches	42	12	30	29
	Participants	1520	353	1167	23

Crisis Management training for Staff and crisis committee members in non Samvedana district	Batches	12	8	4	0
	Participants	445	238	207	0
Reduction of S&D and linkages to +ve HRGs	Batches	46	42	4	91
	Participants	1380	1315	65	95

- In addition to the above mentioned trainings, under the Post Transition Support (PTS), one more workshop was conducted according to the need expressed by the TU teams. That was on the roles and responsibilities of community mobilization staff in CBOs for 13 TIs.

2.7.2.5. Handholding support

- Another key activity under the PTS was to provide handholding support to CBOs where TIs were implemented directly by them. This support focussed on improving financial governance in CBOs which involved activities like book keeping, statutory compliances, support in conducting election and Annual General Body Meeting (AGM). Handholding support in the following areas was provided up to the end of Mar' 2013 for the number of CBOs specified below:

Table 2.10a: Handholding support for the CBOs

Zones	AGM& Refor-mation of Board	Bylaw amend-ment	Renewal of the Registr-ation	New Registr-ation CBO	Obtai-ning 12A & 80G for CBO	Perma-nent Account Number (PAN) / Tax Dduction and Collection Account Number (TAN)	Ann-ual Audit	Inter-nal audit
Belgaum Zone	4	0	0	0	3	0	2	2
Dharwad Zone	12	3	5	0	3	1	5	6
Davangere zone	10	2	1	0	0	0	5	0
Bangalore Zone	5	3	2	1	2	2	2	4
Total	25	8	3	1	5	3	14	12

Table 2.10b: Handholding support for CBOs.

Zones	Membership reconciliation	Reformation of Sub-committees in # TIs	Corpus amount raised	# of Membership including renewals	membership amount raised
Belgaum Zone	1	10	161000	13158	199198
Dharwad Zone	5	6	0	3374	100323
Davangere zone	9	11	128145	5365	74733
Bangalore Zone	4	8	188501	3650	62704
Total	17	35	477646	25547	436958

2.7.2.6. Mentoring visits:

- In addition to the handholding process, mentoring visits were carried out to support the CBOs. The objective of these visits was providing hands on support to the CBOs for building governance structures and systems. KHPT deputed staff and staff from an external agency (Basava Seva Trust) with the expertise in the area carried out these visits.

Table 2.11: Mentoring visits

Persons	Belgaum zone (5 dist)	Dharwad Zone (8 dist)	Davangere Zone (6 dist)	Bangalore Zone (6 dist)	Total
KHPT deputed Staff	32	36	37	38	143 Days
Basava Seva Trust	16 Days	30 Days	16 Days	5 Days	67 Days

2.7.2.7. Promotion of savings and credit facilities in FSW CBOs

- In order to enhance the financial independence of CBOs, KHPT strengthened SHGs in few of the districts and efforts were made to reactivate these thrift groups with appropriate training and hand holding exercises.
- KHPT also supported the FSW community co-operative society ventures. The purpose of the co-operatives was to promote savings and provide credit facilities at low interest rates to its members and also to help them utilize various government economic schemes for the welfare of backward and minority populations to cultivate the habit of savings and provide credit facilities to its members.

- Set of SHG and non SHG record books were printed and distributed to all CBOs to maintain profiles of FSWs, meeting minutes and social entitlement schemes availed.
- Training programmes on book keeping were also conducted in the districts of Shimoga, Chamarajanagar, Hassan, Davanagere and Chitradurga.
- Two more FSW Co-operative Societies were established in Bijapur and Belgaum district and the societies were registered under the Karnataka State Co-operative Societies Act, 1959. In total, there were five FSW Cooperative Societies in the state in Bagalkot, Bijapur, Belgaum, Dharwad and Bangalore.
- A four-day residential training for the Board of Directors of all five co-operative societies was conducted at the National Institute of Co-operative Management, Bangalore to train them to manage and utilize the facility effectively for the benefit of the community. All societies had submitted a list of 200 beneficiaries each from their jurisdiction to the Karnataka State Women Development Corporation (KSWDC) for loan cum subsidy scheme, duly certified by the District CEOs, DAPCU and District Deputy Director of Department of Women and Child Development.

2.7.2.8. Meetings, workshops and other achievements

Apart from the above, several meetings and workshops were conducted. Below is a brief account of the same:

- Sammilana, an MSM CBO was registered in Kolar district in the month of December.
- Snehajyothi Mahila Sangha was registered newly as FSW CBO in Chamarajanagar district in December.
- Two day State level Convention of MSM CBOs was organized in Jan' 2013 in Bangalore. More than 200 MSM and members of the transgender communities participated in the convention.
- A two-day state level convention of transgenders and Jogappas was organized in Bijapur in Mar' 2013.
- 15 FSW CBO representatives attended the International AIDS Conference held at Kolkata in Jul' 2012 with CFAR sponsoring their trip.
- National level workshop on sharing of experiences of learning sites was held in Bangalore in Aug' 2012.
- Monthly review meetings were held with KSAPS regularly.
- Close coordination with the UNTF aided Samvedana project at district level to strengthen support groups and crisis management committees.

2.7.3. Lessons learnt

The Post Transition Support was, in a sense, sequential to the preceding community mobilization processes and activities. It was in line with KHPT's core belief of strengthening CBO and enhancing community ownership of the TI and other vulnerability reduction interventions. Some of the key learning garnered during the implementation of the PTS during 2012-13 is mentioned below:

- Focus on economic independence of individual community members and the CBO as a whole was need of the hour since it was understood that savings was a community priority. Activities towards achieving financial progress and sustenance were well received by the community members. This was an important need of the FSWs and therefore needed focus as part of the program. Strengthening SHGs, linking them to loan cum subsidy services of the government through cooperative societies and generating both internal and external sources of income for the CBO for its sustenance was very effective.
- Linkages with government schemes and programs were much needed to ensure sustainability and mainstreaming of the FSW program. In the PTs experience, the Govt bodies like the WCD and other development bodies responded positively by allocating budget for the program, enrolling FSWs for housing schemes and other development initiatives.
- It was found that the CBO led TIs were performing better than NGO led TIs which reinforces our belief that community ownership is the foundation to any community centred program.
- Addressing violence through community led teams must be preceded by building perspectives about violence among community members. Developing simple formats and building the capacities of the CBO members to report and document violence worked effectively in increasing the confidence of the community in addressing violence.
- CBOs were now increasingly adhering to the guiding principles of CBO building such as adopting democratic processes, ensuring that systems were in place to make CBO leaders accountable and transparent, building second line leadership and respecting diversity among the community members.

2.8. SPRUHA project

2.8.1 Project Profile

2.8.1.1. Partners:

Implementing partners:

Maharashtra: Eduljee Framjee Allbless Niramay Niketan, Bel Air Hospital , St. Joseph Educational and Medical Relief Society, G.M. Priya Health and Development

Society, Snehalaya, Lotus Medical Foundation, Priyadarshini Rural Upliftment Society, Dhanvantari Vaidyakiya Chikitsa Pratishthan, Sangli Mission Society, Sangli Mission Society, Jyothis Charitable Trust, Sai Prem Gramin Vikas Sanstha, Diocese of Chanda Society, Jeevana Vikas Sanstha, Shanti Mandal, Dhanvantris Organisation For Socio-health Transformation, PRIDE INDIA , Karunalaya Trust , Vanchit Vikas , Jai Laxmi Shikshan Sanstha, Late Shriram Ahirrao Memorial Trust, Late Shriram Ahirrao Memorial Trust, YUVA Rural Association, KJ Somaiya Medical Trust, Jay Samka Kalyani Sanstha, Nav Yuvak Gram Sudhar Samiti, Drushti Bahu-uddeshiya Sanstha, Gandhi Memorial Leprosy Foundation, Niramay Arogya Dham, Social Activities Integration, Manavya- children CCC

Karnataka: Sneha Charitable Trust, Accept Society Blesson Philip, Sneha Charitable Trust, Swami Vivekananda Youth Movement, Samraksha, Assissi Society of Assisi Sisters of Mary Immaculate, Society of the sisters of the Holy Cross, Society of the sisters of the Holy Cross, St. Gregorios Dayabhavan, Society of St.Mary's Hospital, The Provincial Congregation of the sisters of St. Charles Borromeo, St. Luke Medical Society, Sumanahalli, Karwar Diocesan Development Council, ORBIT (Organisation of Bidar Integral Transformation), Hemophilia Society, Ashakiran Charitable Trust, Sri Sai International Charitable Trust, Our Lady Of Mercy S.A.B Trust, Shantiniketan Charitable Society, Dhwani Institute for Rural Development, Moogambikai Charitable and Education Trust, Shanthinilaya Community Health Care Centre, Sumanahalli, Health Education Empowerment Rehabilitation Association, Dhwani Institute for Rural Development, Society of the Sisters of St. Joseph's of Tarbes2.8.1.2.

Funders

NACO-Global Fund to Fight AIDS, Tuberculosis and Malaria (NACO-GFATM)

2.8.1.3. Duration

Jan'2008- Mar' 2013

2.8.1.4. Areas of intervention

- Maharashtra:Mumbai, Pune, Thane, Raigad, Ratnagiri, Kolhapur, Sangli, Satara, Solapur, Osmanabad, Latur, Nanded, Beed, Ahmadnagar, Aurangabad, Nashik, Jalgaon, Dhule, Nandurbar, Jalna, Parbhani, Hingoli, Buldhana, Washim, Akola, Amravati, Yevatmal, Wardha, Nagpur, Bhandara, Chandrapur, Gondia, Gadchiroli.
- Karnataka: Belgaum, Bijapur, Bagalkot, Bangalore, Bidar, Bellary, Chamrajnagar, Chikmangalur, Chikballapur, Chitradurga, Dakshin Kannada, Davangere, Dharwad, Gadag, Gulbarga,Haveri, Kolar, Koppal, Mysore, Mandya, Ramnagara, Raichur, Shimoga, Tumkur, Uttar Kannada, Udupi.

2.8.1.5. Target Community

PLHIV

2.8.1.6. Goal of the project

An increased number of PLHIV have access to better quality of life and reduced vulnerability through improved clinical and care services, linking with relevant social services and community responses.

2.8.1.7. Objectives of the project

- To expand the coverage of and access to services for PLHIV.
- To expand the scope of services provided to PLHIV.
- To ensure PLHIV receive various services in an environment without stigma, discrimination and denial.

2.8.1.8. Background of the project

The To improve the adherence level among PLHIV, an experiment was conducted in Govt Hospital of Thoracic Medicine, at Tambhram. "In this experiment, it was realised that if people were provided with appropriate and intense counselling at the initiation of ART, the likelihood of them being adherent was much higher" (Our projects). The CCC was transformed to a place where PLHIV could stay for a short while and was envisaged as a link between home based care and the tertiary care unit. The CCCs would work with the ART centres. The outreach workers from the CCC would also support in follow ups (Our projects). Community Care Centres (CCC) concept was scaled up through a proposal by NACO to GFATM in the round 6 applications, which resulted in the roll out of the CCC program under NACP-3 in its new form with revised guidelines.

At the beginning of the project, 11 CCCs were transitioned to KHPT (2 from MSACS and 9 from KSAPS). The project successfully scaled this up to establishing 90 CCCs across two states (48 in Maharashtra and 42 in Karnataka). These centres were located in 59 districts (33 in Maharashtra and 26 in Karnataka)according to the epidemiological profile of the districts and were linked to the nearest ART centres. They served as a hub in the care and support program, linking clients to a complete range of medical services for Antiretroviral Therapy and management of opportunistic infections, orphanages, destitute homes, hospices, vocational training centres and legal support services.

2.8.2. Activities/Outcomes

2.8.2.1. Services provided

- During the period Ap' 12 to Mar' 13, the CCCs in Karnataka and Maharashtra had provided the following services:

Table 2.12: Services provided for the states of Karnataka and Maharashtra

Particulars	Maharashtra		Karnataka		Total for SPRUHA	
	Apr' 2012 to Mar'13	Cumulative since inception	Apr' 2012 to Mar' 13	Cumulative since inception	Apr' 2012 to Mar' 13	Cumulative since inception
Registration (Individuals)	10100	68392	10605	61345	20705	129737
Out Patient(OP) (episodes)	44340	212064	46012	200390	90352	412454
In Patient(IP) (episodes)	18703	94571	16803	73777	47847	225131
Opportunistic Infection treated (episodes)	32074	150686	29144	130560	61218	281246
Total Counselling (sessions)	115356	527380	174959	684306	290315	1211686
Adherence counselling (sessions)	32911	139845	38446	140654	71357	280499
Family counselling (sessions)	22711	102112	25447	100229	48158	202341
Other counselling (sessions)	59734	285423	111066	443423	170800	728846
In-referrals from ART centres (Individuals)	4623	33031	7302	30813	11925	63844
Out-referrals to ART centres (Individuals)	2472	11450	11634	35463	14106	46913

- Average bed occupancy for the project: 91.5 %
- Average bed turnover ratio for the project: 5.3 days

- Approximately 100,000 care givers of PLHIV were trained in adherence, nutrition, positive prevention, home based care and vocational training.
- KHPT also provided technical support to a 50 bedded residential CCC for children in Maharashtra, which was a pilot programme of NACO.

2.8.2.2. KHPT's contribution at national level

- Member of "Technical Resource Group" on Care & Support Services, NACO.
- Member of "Working Group" on development of training modules for CCC staff.
- Active contribution in the process of finalization of the national levelComputerised Management Information System (CMIS) in consultation with NACO and Population Foundation of India (PFI).

Photo 2.4 Overall view of CCC

2.8.3. Lessons Learnt

- The CCCs served as a hub in the care and support program, linking clients to a complete range of medical services for antiretroviral therapy and management of opportunistic infections, orphanages, destitute homes, hospices, vocational training centres and legal support services. Thus, a strong co-ordination with all the HIV and non-HIV stakeholders is important.
- There was a need to integrate various aspects of the program with existing government programmes and schemes such as Revised National TB Control Program (RNTCP), NRHM. Although these linkages were in process at a theoretical level, their convergence in the field was yet to be seen.
- The program was being implemented by NGOs, a majority of whom had a moderate corpus. For them to function effectively, timely grant disbursal was essential. Due to interrupted fund flow, there was a huge staff turnover causing loss of trained personnel person power. In the absence of adequate fund flow, the partner organizations had sustained the activities for several months by advancing the CCC project from their parent organizations and also by raising local resources. This reflected a tenacity of the organizations to work with the

project and to provide uninterrupted services to PLHIV.

- The programme was being transitioned into Care and Support Centre (CSC) programme. The CCCs initiated the process for transition a few months in advance where in they engaged with the clients informing them about the impending change, reasons for the same, services available at various centres/offices etc. This ensured uninterrupted service provision to PLHIV in the phase of transition.

2.9. Sukshema-MNCH Project

2.9.1 Project Profile

2.9.1.1. Partners:

Implementing partners: University of Manitoba (UoM), St.John's National Academy of Health Sciences, Karuna Trust, Intra Health, and Government of Karnataka.

2.9.1.2. Funders

Bill and Melinda Gates Foundation (BMGF)

2.9.1.3. Duration

Sept'2009- Sept'2014

2.9.1.4. Areas of intervention

Bagalkot, Bellary, Bidar, Bijapur, Gulbarga, Koppal, Raichur and Yadgir. 2.9.1.5.
Target Community
Frontline Workers (FLWs); Supportive Community Monitoring Team (SCMT).

2.9.1.6. Goal of the project

To support the state of Karnataka and India to improve Maternal Newborn and Child Health outcomes in rural populations through the development and adoption of effective operational and health system approaches within the NRHM.

2.9.1.7. Objectives of the project

Below mentioned are the objectives of the project

- Enable expanded availability and accessibility of critical MNCH interventions for rural populations.
- Enable improvement in the quality of MNCH services for rural populations.
- Enable expanded utilization and population coverage of critical MNCH services for rural populations.
- Facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels.

2.9.1.8. Background of the project:

"In 2010, BMGF awarded funds to the University of Manitoba, in partnership with the Karnataka Health Promotion Trust (KHPT), St John's National Academy of Health Sciences, Intra Health and Karuna Trust to support the Government of Karnataka in developing strategies to improve MNCH among the rural poor in eight districts in northern Karnataka: Bagalkot, Bellary, Bidar, Bijapur, Gulbarga, Koppal, Raichur and Yadgir.... As a part of developing the implementation strategy for the project, a situational assessment was carried out in the project districts. While the findings of these assessments provided inputs to the identification of critical gaps and development of solutions within the project, these assessments also provide an opportunity to promote data-based planning at the district level, an important component of the project (Our projects)."

2.9.2. Activities and outcomes of the project

2.9.2.1. Implementation of the project activities and scale up

- The on-site mentoring intervention was piloted in two districts – Bellary and Gulbarga – and the intervention was scaled up to all the 24x7 PHCs identified during the facility mapping in 2010, in the remaining 6 districts.
- The scale up of community interventions were piloted in Bagalkot and Koppal districts and were initiated in the remaining 6 districts. A total of 60 community coordinators were in place in 8 districts supporting 884 resource persons or FLW facilitators.

2.9.2.2. Onsite clinical mentoring on supportive supervision to staff nurses through nurse mentors.

Photo2.5: Drug chart and complication specific kits

- In order to improve the quality of care at birth and in the immediate postpartum period, the project proposed to test and implement the strategy of providing on-site clinical mentoring and supportive supervision to staff nurses in 24x7 PHCs, through a dedicated cadre of nurse mentors.
- A total of 284 24x7 PHCs in the eight districts were covered with the clinical mentoring intervention, with a total of 55 nurse mentors.
- The mentors were able to work with PHC to develop quality improvement processes and had built rapport with the team.The PHC teams was willing to engage with the mentors in quality improvement sessions. In many PHCs, teams were initiating their own reviews and resolving their own problems in between mentor visits. For example, in one PHC, staff made their own charts with Post Natal Care (PNC) messages, which they posted above the observation bed so they would remember the messages.
- The use of team-based quality improvement processes, combined with mentors providing on-going support, had generated improvements in the quality of care at PHCs. The improvements were
  - improved availability of drugs and supplies.improved organisation of labour rooms.
  - decreased labour augmentation.
  - improved adherence to Skilled Birth Attendant(SBA) guidelines for normal deliveries.
  - increased capacity and confidence to manage maternal and new born complications.
  - better referral processes was observed by use of team based quality improvement processes combined with support.

Table 2.13 Coverage of the mentoring intervention

District	# of 24x7 PHCs as per Sukshema mapping in 2010	# of 24x7 PHCs covered by mentoring intervent-ion	# of Nurse mentors (Mar 13)	Month started the interven-tion	Number of mentoring rounds completed (Mar 2013)	Number of mentoring visits completed (Mar13)
Bagalkot	38	39	6	Feb, 13	1	117
Bellary	52	26	6	Aug, 12	4	312
Bidar	34	35	7	Nov, 12	2	210
Bijapur	36	36	4	Dec, 12	3	324
Gulbarga	56	28	6	Aug, 12	4	336
Koppal	38	42	7	Feb, 13	1	84
Raichur	46	46	7	Dec, 12	2	126
Yadgir	31	36	5	Nov, 12	2	216
Total	331	288	48		19	1725

- Although it is early to expect major gains through the mentoring intervention in the outcomes, there was an indication of certain positive changes, as per the case sheet summaries in the two pilot districts that had received six mentoring visits (Figures 2.4 and 2.5).

Figure 2.4: Trends in key outcomes for mothers and newborns in PHCs that received mentoring, Bellary district

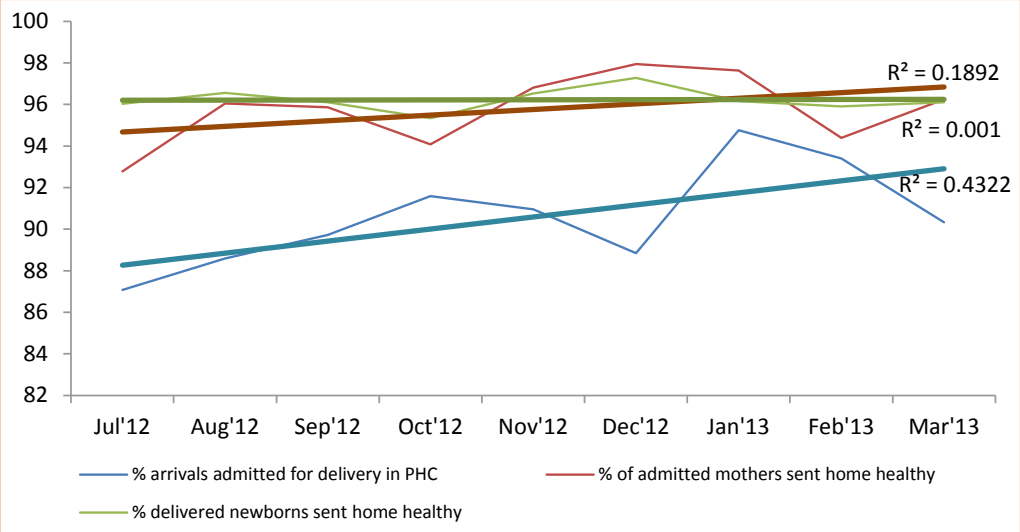
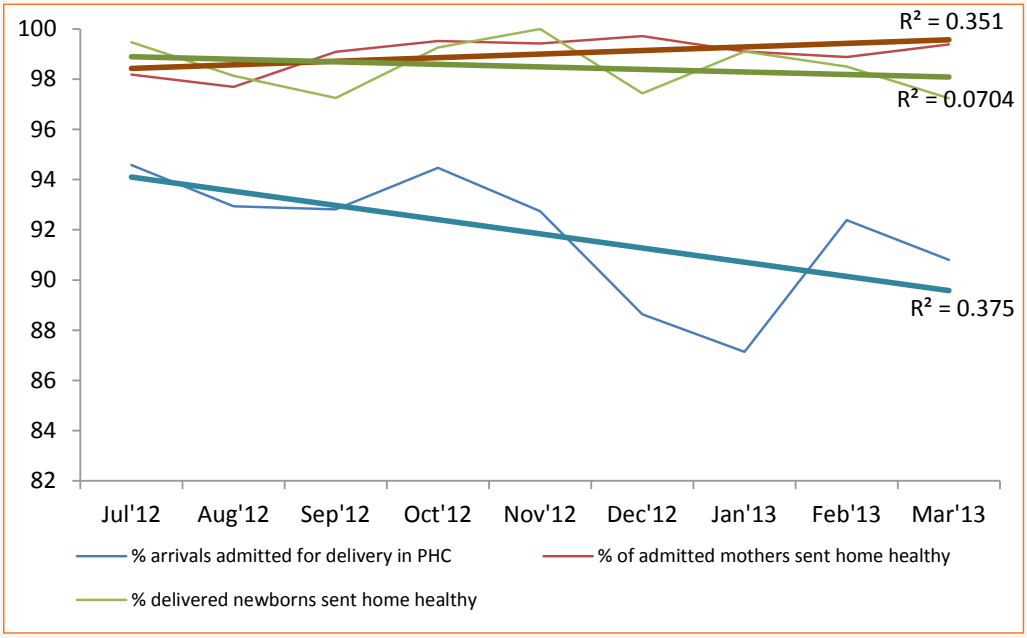


Figure 2.5: Trends in key outcomes for mothers and newborns in PHCs that received mentoring, Gulbarga district



2.9.2.3. Training of the nurse mentors

During the reporting period, a total of 55 nurse mentors were trained for a period of five weeks in three batches, in collaboration with St. Johns Medical College and Hospital, using the training and participant manuals developed by the project. The mentors also received refresher trainings, led largely by Dr. Swaraj Rajbhandari, Intra Health. The clinical postings for mentors from Bagalkot and Koppal were planned after the completion of the third mentoring visits.

Table 2.14: Training and refresher trainings for the nurse mentors

Training period	Districts	# trained
10th Oct' – 9th Nov' 2012	Bidar	8
	Yadgir	5
	Gulbarga	1
	Bellary	1
29th Oct' 29 – Nov' 31 2012	Raichur	7
	Bijapur	6
	Bellary	1
Jan' 7 – Feb' 6 2013	Koppal	7
	Bagalkot	6
	Bellary	2
Total nurse mentors trained for the project, including those trained in the previous reporting period: 55		
Date of refresher training	Districts, positions and numbers trained	
10th Jan - 11th Jan' 13	20 mentors and 4 District Program Specialist's (DPS) from Bellary, Gulbarga, Bagalkot, Koppal	
18th Jan - 19th Jan' 13	26 mentors and 4 DPS's from Raichur, Bijapur, Bidar, Yadgir	

2.9.2.4. Tools and job aids

- In order to improve the management and delivery of outreach services, the project developed, field tested and implemented in the 8 project districts a set of tools and job aids for frontline workers (FLWs). These tools were designed to help the FLWs to enhance coverage along the continuum of care, assist in communicating with families about critical MNCH services and strengthen the provision of quality Post Natal Care (PNC) visits. The tools and training modules were developed and implemented for FLWs in two districts initially (Bagalkot and Koppal), with a view to implement them in the remaining 6 districts subsequently. The tools were Enumeration and Tracking Tool (ETT), Home-Based Maternal and Newborn Care (HBMNC), training module for FLWs on family focussed communication, Supportive Community Monitoring Tool (SCMT).
- The following key activities related to this intervention were completed during the reporting period:

Table 2.15: Key activities under the project

Implementation steps in the pilot districts – Koppal and Bagalkot	Dates
Development of job aids and tools	Apr' 2012
Recruitment and training of RPs	Mar' 2012
Baseline Community Behaviour Tracking Survey(CBTS)	Jun'2012
Family Focused Communication (FFC) Training of Trainers (ToT) for RPs	May 2012
ETT Training of Trainers (ToT) for RPs	Sep'2012
HBMNC Training of trainers(ToT) for RPs	Jan'2013
FFC Roll outs	July, Aug and Sept'2012
ETT Roll out	Oct, Nov and Dec'2012
Arogya Mantapa roll out	2012
HBMNC roll out	Jan-Feb'2013

- Work was undertaken on development on communication material such ASHA diaries, ASHA reminder cards, calendar on birth preparedness. There was a delay in the training of FLWs in the "scale-up" districts. Several revisions were made to the ASHA diary and final approval is awaited.
- The resource persons were moved from pilot districts of Bagalkot and Koppal to scale up districts. A total of 6 RPs were transferred to the remaining six project districts as district community intervention specialists and 32 as community intervention coordinators to help with the scale-up of community interventions.
- Plans for FLW trainings in the scale up districts were worked on for training on the tools and methods described above (Table 2.16).

Table 2.16: plan for FLW training

District	ASHA	Anganwadi Worker (AWW)	JHA	Total FLWs
Bijapur	1,377	1,877	303	3,557
Bidar	1,310	1,611	281	3,202
Yadgir	921	1,227	168	2,316
Gulbarga	1,591	2,573	327	4,491
Raichur	1,288	2,234	213	3,735
Bellary	1,470	2,138	293	3,901
Total	7,957	11,660	1,585	21,202

2.9.2.5. Monitoring and evaluation

- Behaviour tracking surveys were planned to monitor changes in selected indicators related to knowledge, practice and utilization of critical MNCH services among women who delivered in the previous two months. A set of 20 field researchers were trained and deployed for the data collection using mobile phones. The first round of data collection in all eight districts was completed, and the second round was completed in Bagalkot and Koppal districts.
- The project developed tools for the Resource Persons (RPs) to report coverage for MNCH services by FLWs using an abstract of the Enumeration and Tracking Tool (ETT) and the Supportive Community Monitoring Tool (SCMT). Other tools used for monitoring the intervention included the training reports, and resource persons mentoring reports. The ETT summaries were analyzed regularly by the resource persons to provide support to the FLWs.
- The strategy adopted by Sukhshema in the pilot districts was to recruit and train a separate cadre of Community Coordinators at taluka level and RPs at PHC levels, to provide field-based mentoring support to the FLWs in the use of the above tools, and methods to improve the frequency and quality of interaction between FLWs and families (Table 2.17).

Table 2.17 Details of community interventions in the project districts

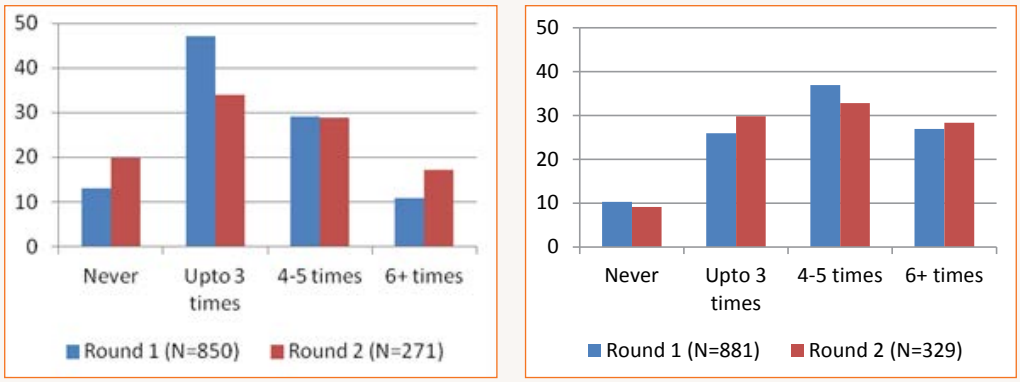
District	# of PHCs	# of SCs	# of ASHAs sanctioned	District Community Intervention Specialist1	Taluka Community Intervention Coordinator1	Resource persons
Bagalkot	45	219	1215	1	6	38[1]
Koppal	42	175	1086	1	4	40[1]
Raichur	48	213	1288	1	8	104[2]
Bellary	55	293	1470	1	9	110[2]
Gulbarga	81	327	1591	1	12	164[2]
Yadgir	42	166	921	1	6	96[2]
Bijapur	53	300	1377	1	8	120[2]
Bidar	44	270	1310	1	7	102[2]
Total	410	1963	10258	8	60[3]	884

[1] Sukshema project staff
[2] Government staff identified as RPs
[3] 32 are were part of the pilot in Bagalkot and Koppal districts

2.9.2.6. Community Behavioural tracking surveys

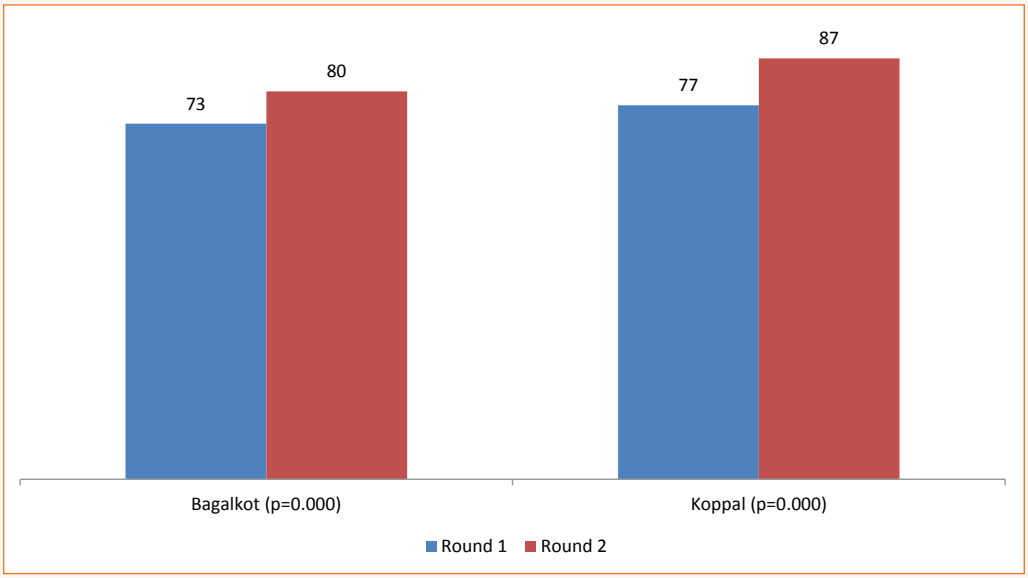
- Sukshema completed two rounds of community behavioural tracking surveys at a nine-month interval (Jun-Jul' 2012 and Mar'-Apr', 2013). This involved recently delivered mothers from randomly sampled ASHA areas in Bagalkot and Koppal districts. Although, early to establish significant improvements in the coverage and utilization of key services, the data was indicative of positive trends.
- For example, the number of interactions between the ASHAs and the recently delivered women during the antenatal period in Bagalkot district increased significantly between the two survey rounds from an average of 3.1 to 3.5 (Figure 2.6). However, the increase was not statistically significant in Koppal district (from an average contact of 4.2 to 4.4).

Figure 2.6: Percent distribution of interviewed women who had delivered in the past 1 month, according to the number of times she was visited by an ASHA during pregnancy.



- The data showed a significant increase in the mean number of ANC check-ups received by the interviewed women, i.e. from 3.8 to 4.8 in Bagalkot and from 4.0 to 5.3 in Koppal district. The proportion of women who received 3 or more Ante Natal Care (ANC) check-ups from a facility or a health care provider increased from 73% to 80% in Bagalkot and from 77% to 87% in Koppal district (Figure 2.7).

Figure 2.7: Percentage of interviewed women delivered in the past 1 month who received 3 or more ANC checkups from a health facility or provider



- There was a decline in the proportion of home deliveries, and the decline was statistically significant in Koppal district (Figure 2.8). There was a statistically significant increase in the proportion in Bagalkot district of recently delivered mothers who breastfed their newborns within an hour of birth (Figure 2.9).

Figure2.8: Percentage of interviewed women delivered at home in the past 1 month

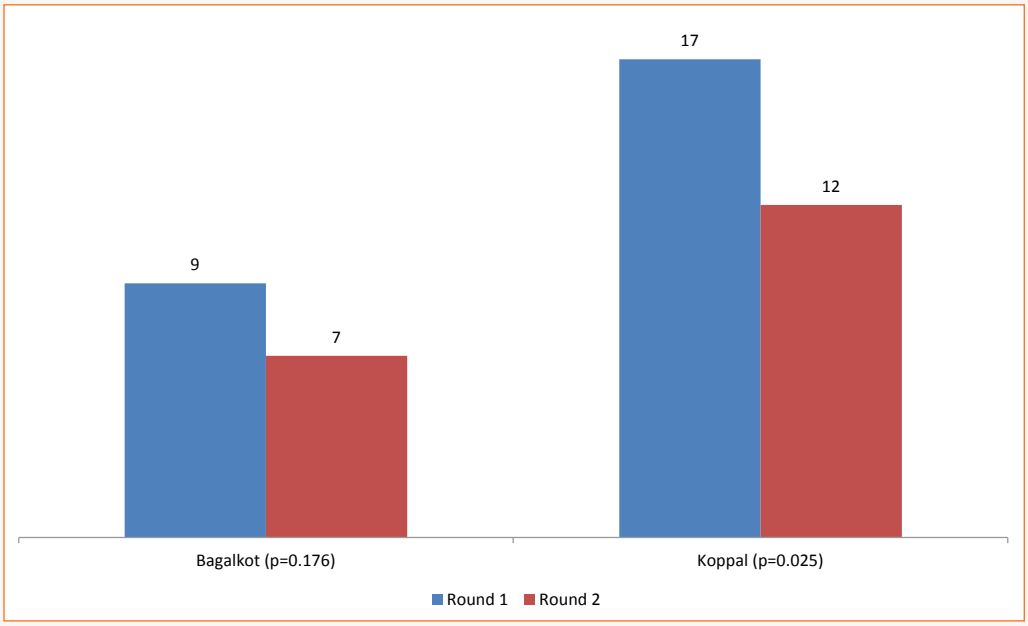
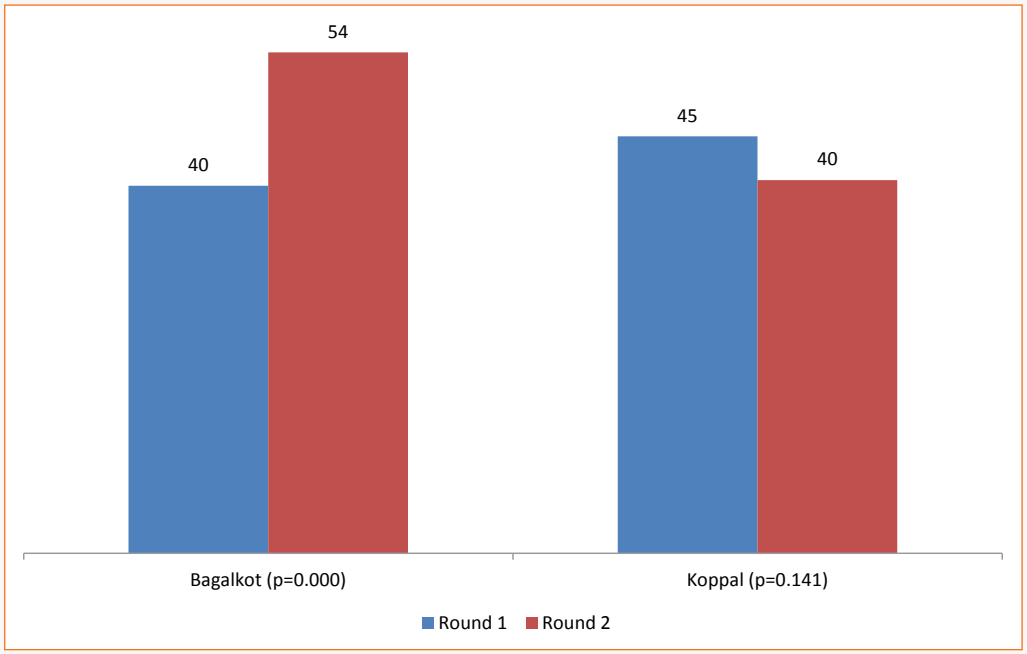
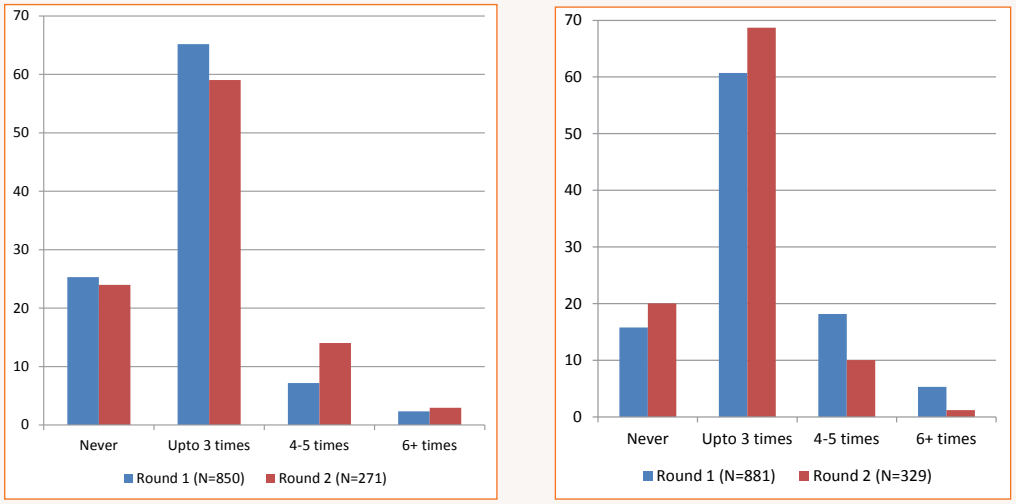


Figure 2.9: Percentage of interviewed women delivered in the past 1 month who breastfed the newborn within the first hour of birth



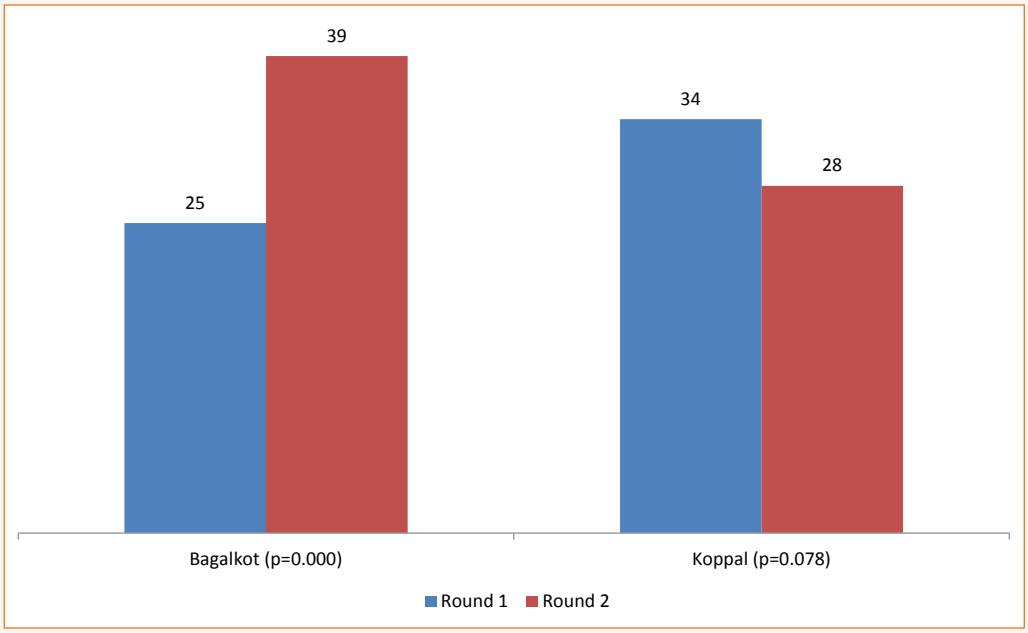
- The number of interactions between ASHAs and the recently delivered women during the postnatal period showed a significant increase between the two survey rounds in both Bagalkot and Koppal districts (Figure 2.10).

Figure2.10: Percent distribution of interviewed women who had delivered in the past 1 month, according to the number of times she was visited by an ASHA during pregnancy



- The percentage of women who received all key services under the continuum of care (i.e. received 3 ANC checkups, had an institutional delivery, a post-partum check-up in the facility within 48 hours after delivery, and received a PNC visit at home) showed a significant increase in Bagalkot between the two surveys rounds (Figure2.11).

Figure 2.11: Percentage of interviewed women delivered in the past 1 month, who received key services under the continuum of care



2.9.2.7 Software program

- The project developed software so that HMIS data analysis could be automated, for the Block Program Managers (BPMs), District Program Managers (DPMs) and other district health officials. This software was well received by state officials.

2.9.2.8. Meetings

Photo 2.7: Sukhshema meeting, June 2012

Photo 2.8: Sukshema meeting , June 2012

- During 11th Jun' -14th Jun', 2012, a meeting cum retreat was organised near Bangalore for Sukshema staff. In this meeting, discussions were about Sukshema intervention design, role clarification and workplans, details of community and on-site mentoring interventions, and on intervention monitoring tools.
- On 16th Dec' 2012, meeting with BMGF was organised.
- On 11th Feb' 2013, review meeting with UoM and BMGF was organised.
- On 12th Feb'-13th Feb'2013 four teams visited to Bellary, Gulbarga, Bagalkot and Koppal.
- On 14th Feb'2013, review meeting was organised.
- During 6th Mar-7th Mar'2013, a meeting was organised in Hospet and field visits wereorganised in Hospet and Koppal.

2.9.3. Presentations/consultations

2.9.3.1. Abstract presentations:

- Krishnamurthy J, Avery J, Ramesh BM, Bhowmik A, Thomas A, Bhat SR, Mony P, Fischer B, Selva Kumar, Moses S, and Blanchard JF. Quality of postpartum care in the community: assessment from rural areas of Northern Karnataka, India; International Federation of Gynaecology and Obstetrics (FIGO) World Congress; Rome; Oct 7-12, 2012.
- Krishnamurthy J, Ramesh BM, Bhowmik A, Thomas A, Mony P, Shankar K, Rajiv Ranjan, Schurmann A, Selva Kumar, Blanchard JF, Moses S and Avery L. Management of eclampsia and postpartum hemorrhage: Challenges and opportunities to

- improve quality of care in northern Karnataka, India; International Federation of Gynecology and Obstetrics (FIGO) World Congress; Rome; Oct 7-12, 2012.
- Dr. Troy Cunningham; Improving quality of maternal and newborn health through a mentoring process: results of a baseline survey in northern Karnataka; Global Maternal Health Conference; Arusha, Tanzania; January 15th -17th, 2013.
- Dr. Prem Mony; Improving quality of maternal and neonatal health care in Primary Health Centres: Design and implementation of an on-site nurse mentoring programme in Karnataka state, India; Global Maternal Health Conference; Arusha, Tanzania; January 15th -17th, 2013

2.9.3.2. Consultation

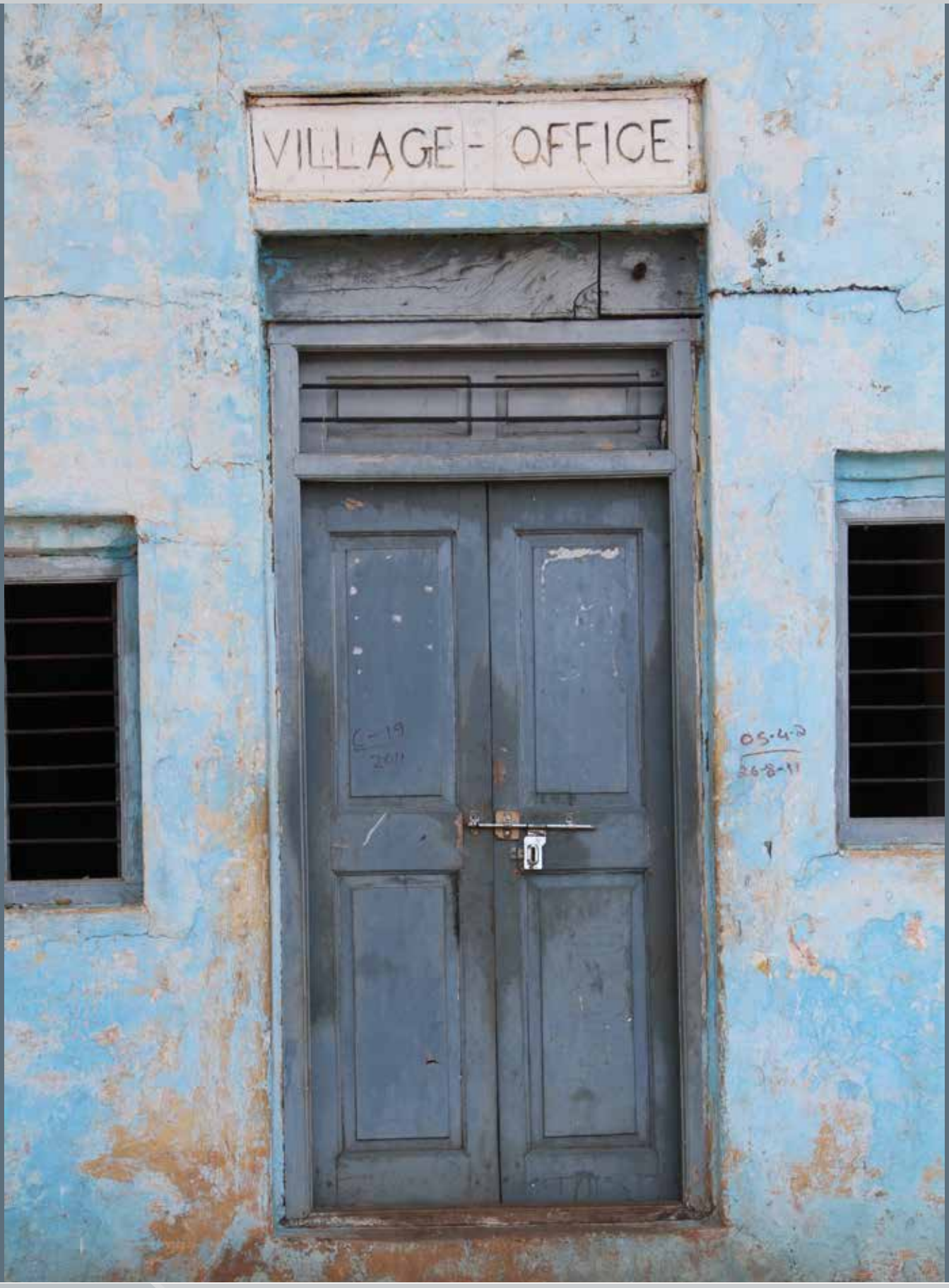
- Sukshema was represented by Dr. J. Krishnamurthy at the India National Consultation on Supportive Supervision to Strengthen Capacities of Front Line Workers and Service Providers organized by UNICEF, the Ministry Of Health and Family Welfare (MOHFW) and the Ministry Of Women and Child Development (MOWCD) in New Delhi, 22nd-23rd Nov' 2012.

2.9.4. Challenges

- Some of the challenges in the mentoring intervention were lack of adequate support for quality improvement process due to vacant medical officer positions in certain PHCs, and over-crowding in some PHCs, staff turnover, etc.
- Some of the areas that were slow to improve were:
  - Improvement for infection prevention in the labour rooms.
  - 48 hours stay of the mothers in the facility after delivery.
  - Inadequate postpartum care since the monitoring is less after delivery.
- The project was not successful in organizing state level policy workshops related to the re-distribution of functional facilities per population and geography, to address the issues of incentives for FLWs, and to address the issues of staff, drugs and supplies. Due to changes in the government leadership, there was insufficient support for these activities.
- There were delays in approvals for printing and approvals for printing and sitribution of FLW job aids due to changed leadership in the government and availability of goveremnt staff for training due to elections was a challenge.

2.9.5. Lessons learnt

- Participation of FLWs and providers in the development of tools and job aids: One of the key lessons learned in Sukshema was that involvement of the key stakeholders in the development and implementation of tools and job aids greatly increased the likelihood of them being used and sustained.
- Strong coordination at the field level between community and facility programs was critical for program impact. In recognition of this, project leadership was reorganized accordingly.
- Joint field visits and joint reviews with field staff, using data generated as a guide helped in make necessary changes in program planning and implementation.
- Periodic program reviews were useful to bring in objective perspectives. These led to several important changes in the implementation design of both the community-based and facility-based interventions. For example, mentoring visits were now scheduled once every two months for each PHC, and each visit lasted 3 days, unlike the earlier monthly 2-day visits, that did not allow for high-quality interactions. The need to strengthen the skills of the Resource Persons (RPs) in using the Enumeration and Tracking Tool data for planning was also identified during a program review meeting, and that led to the development of simple tools and enhanced trainings for RPs.


VILLAGE - OFFICE

Section 3

Research initiatives

Section 3 Research initiatives

3.1. An Assessment of Sexual and Reproductive Health (SRH) needs of HIV infected adolescents in six districts of Karnataka State (Mar' 2012-Mar' 2013).

3.1.1 About the study:

This study was undertaken by Indian Council for Medical Research (ICMR) in partnership with KHPT, KSAPS and JJM Medical College, Davangere. It was conducted in 6 selected districts of Karnataka. The aim of the study was to develop interventions to integrate these needs into the existing HIV/AIDS treatment, care and support programs.

The objectives of the study are mentioned below

- Assess the sexual and reproductive health (SRH) needs of HIV positive adolescents.
- Assess the parents or guardians and care providers' perspective towards adolescent SRH needs.
- Assess existing HIV/AIDS treatment, care and support programs and identify information and services gaps in relation to SRH for HIV positive adolescents.

This was a cross sectional study and adopted an exploratory design using a combination of quantitative and qualitative approaches. The target sample size was 600.

3.1.2. Outcomes:

Some of the conclusions were

- Choice of Methodology for a study like this- itself is a matter of debate. Combined approach to elicit information relatively free from bias on the interviewer as well as the respondent was selected. Continuing the qualitative method (FGDs) to completion however could not be done due to non availability of the respondents of the specific age groups. Further, qualitative studies are required to explore the sexual and reproductive health needs of the HIV infected adolescents.
- Poor knowledge regarding and Reproductive Health amongst the HIV infected adolescents.
- Source of information was friends from neighbourhood and schools and preferred source of information was school or health centre.
- Support systems for adolescents included discussing their problems with mother, friends at school or neighbourhood.

- There was scope of improvement on the sex education classes as 50% adolescent PLHIV did not know anything about classes on sex and reproduction in school, or about the available services.
- Disclosure of HIV status to the adolescent infected with HIV was an area of major concern as there was a wide gap in the assessment at the counsellor level on disclosure and the individual adolescent level.
- As per the study, HIV positive adolescents constructed their lives positively and showed much hope for future and achieving dreams.
- In conclusion, adolescents infected with HIV had the same aspirations as those who were not HIV-infected.

3.1.3. Recommendations of the study:

- SRH services for young PLHIV to have a strong focus on disclosure and self esteem.
- This study indicated that wide programmatic gaps existed in addressing the sexual and reproductive health needs of young people infected with HIV who were growing into sexually active adolescents and adults. This evidence provided a concrete basis for generating discussions on how existing HIV/AIDS programs can change to provide young people with information and services.
- The study recommended reorientation of service providers/ counsellors on disclosure of HIV status to the adolescents.
- The study recommended strengthening of adolescent clinics to cater to young adults and be sensitive to their age.
- The prevention services can be strengthened.HIV/AIDS treatment centers that provide care and support will need to improve their access to information and integrate with services for family planning and HIV prevention.
- The parents can be involved to discuss sexual health with adolescents.
- The peer groups can be strengthened to provide information on reproductive and sexual health.
- The life skills of HIV positive adolescents can be improved.

3.2. An Assessment of the burden of pediatric HIV in "A" category districts

in India(Aug'2012- Nov' 2014)

3.2.1. About the study

The study'estimating the burden of Pediatric HIV in a "A" Category district in India' was an ICMR task force research study. The study was being undertaken in partnership with ICMR, NACO, KSAPS, St John Research Institute (SJRI) and KHPT.

The overall objective of the study was to estimate the disease burden of paediatric HIV among children in a category 'A' district of the high prevalence state. The other objectives are mentioned below

- **Primary:**
  - Early case detection in infants (0-18 months) born to HIV positive women.
  - Case detection in children (0-14 years) born to HIV positive parents referred from ICTC centers, blood banks and NGOs in the districts by age appropriate testing.
  - Case detection in sick children (0-14 years) presenting with suspected signs symptoms, & meeting the modified Integrated Management of Neo-natal and Childhood Illness (IMNCI) HIV screening criteria for testing at heath care facilities by age appropriate HIV tests.
- **Secondary:**
  - To identify arithmetic factor to arrive at the best estimate of HIV burden among children that correlates best with the HIV prevalence rate among pregnant mothers.
  - To identify the most efficient methods that enhance pediatric case detection and appropriate referral for HIV care.
  - To assess the validity of modified IMNCI HIV among sick children.
  - The study design included a multi-pronged approach to enhance case detection of pediatric HIV over a one year period and the study had used different strategies to include the all pediatric HIV cases.

The study participants criteria is mentioned below

- Children, 0-18 months, born to HIV infected women, registered between 01st Jan'2011 and 31st May 2013.
- Children, 0-14 years, of adults living with HIV, detected between 01st Jan' 2011 and 31st Mar' 2013.
- Sick-children, 0-14 years, satisfying modified IMNCI criteria at select health facilities, between 01st Aug' 2012 and 31st Oct' 2013.

The sample size was 461 pregnant HIV positive women, positive parents (461) and sick children as identified using IMNCI-HIV criteria: 1037. The study was recommended to continue till 30th Nov 2014.

3.3. CHARME project

3.3.1. About the project

The CHARME project used sophisticated mathematical modelling techniques in combination with collection of enhanced serial cross-sectional behavioural and STI/HIV

prevalence data to investigate transmission dynamics among and between core, bridge and general population groups, to understand the effects of, and to estimate HIV cases averted by, the interventions, and to construct future scenarios for the HIV epidemic in the four Southern states of India covered by Avahan. Costing and cost-effectiveness analyses were also conducted. In addition to the Integrated Behaviour and Biological Assessment (IBBA) collected as part of another monitoring and evaluation project under Avahan, special behavioural surveys among female sex workers and men who have sex with men in seven districts were conducted, as well as general population surveys in four districts (these are the data made publicly available).

3.4. Experience of violence and HIV related risks and vulnerability among women in sex work in Karnataka (2012-2013)

3.4.1. About the study

The overall aim of this study was to analyze the current level of violence among sex workers and its relationship with sex work characteristics and associated risks and vulnerabilities under the umbrella of community empowerment. However, the specific objectives were:

- To measure the current level of empowerment among FSWs and the factors associated with the high levels of empowerment.
- To examine the relationships empowerment and the experience of different forms of violence.
- To examine the relationships between empowerment, violence, and HIV related risks and vulnerabilities.

Four districts were selected for the data collection- Belgaum, Gulbarga, Gadag and Dharwad. The data was collected from 1464 women (Karnataka Health Promotion Trust, 2013).

3.4.2. Outcomes

Some of the findings of the study were

- Half of the women in the selected districts had high level of empowerment.
- The women were aware of the causes, consequences and perpetrators of violence.
- 35% of women experienced violence from intimate partner/ husbands in the 12 month period before the survey where physical, sexual and other forms of violence were 30%, 10% and 26% respectively.
- Association between level of empowerment and experience of violence was found, for example, women from higher category of the empowerment were less

likely to experience physical violence from intimate and non intimate partners.

- The study did not find any significant linear relationship between empowerment, HIV risk and vulnerability related outcomes (Karnataka Health Promotion Trust, 2013).

3.4.3. Recommendations

- The findings of the program can be used in a program addressing violence, stigma and discrimination among the community women.
- The study recommends strategy to empower women such as community outreach, peer education and formation of networks.
- The study indicated work can be undertaken in the direction of service utilization and linkage of social entitlements. The strategy can be to build the capacity of the service providers, creating awareness, having committees on anti VAW with representatives from legal and health sector (Karnataka Health Promotion Trust, 2013).

3.5. STRIVE

3.5.1. About the program

STRIVE is an international Research Program Consortium (RPC) that generates rigorous research into what works to tackle the social, political and economic factors that facilitate HIV transmission or impede prevention efforts. Specifically, the STRIVE consortium focuses on 4 interlocking drivers:

- Gender roles and inequities: that is culturally and institutionally reinforced and structure men and women's sexual behaviour, economic opportunities and power and vulnerability to violence and that undermine their efforts to avoid HIV (this will include violence, masculinity and male norms and Gender Based Violence).
- Stigmatization, discrimination and criminalization: that prevents people from getting HIV tested and hinders the efforts of MSM, sex workers and other marginalized or disempowered groups to prevent HIV and / or access services.
- Poor livelihood opportunities: that shape patterns of sexual mixing, deplete hope, self efficacy and trust, foster risky behaviour and hinder HIV prevention and treatment efforts.
- Unrestricted alcohol availability and drinking norms: which may directly influence HIV risk and exacerbate sexual risk taking and gender based violence.

Together and individually these structural factors undermine the effectiveness of HIV prevention and treatment programs and global ambition to eliminate HIV will only be achieved if effective approaches to addressing the structural drivers of HIV are identified and implemented at scale. (Director Communications, KHPT Annual report 2011-12 , 2013)

3.5.2. Outcomes and achievements

3.5.2.1. Samvedana Plus

- Research initiatives for the Samvedana Plus project included working on the intervention design, working on the monitoring and evaluation design of the project, qualitative data collection, piloting of key strategies.

An enumeration study on 'Understanding the relationship between female sex workers and intimate partners in the context of support, risk and vulnerability' was undertaken by STRIVE. The overall objective of the study was to develop a profile of FSWs and their IPs.

Specific objectives were:

- To understand HIV risk for FSWs from their IPs.
- To understand the types and levels of support FSWs receive from their IPs.
- To understand FSWs' experiences of violence from their IPs.

This quantitative study used a cross-sectional descriptive study design. The study was designed to enumerate FSWs in two intervention areas Bagalkot and Bijapur. In total, 3207 FSWs (92% of the estimated FSWs) from 123 villages and 7 towns of the two districts of Bagalkot and Bijapur were enumerated.
The findings of this enumeration highlighted the fact that for FSWs, the relationship with their IPs is an important part of their lives. While support from the IP may be related to an increased use of condoms, in the case of some FSWs, this does not protect them from violence at the hands of their IPs. But the risk of both non-use of condoms and acts of violence by the IP increases when the FSW is involved with more than one IP (Prabhughate, Javalkar, & Doddamane, 2013).

3.5.2.2. Sabala project

- Research initiatives for Sabala project included working on the intervention design, evaluation design, desk review and analysis of existing data on young girls entry into sex work in the intervention area. The process of Sabala's implementation was being monitored by recording and analyzing project implementation data and reporting the information to managers and relevant stakeholders to enable them to determine whether the project implementation was undertaken.The project spent lot of time through discussions and facilitated debates within the team to develop the Theory of Change (TOC). Facilitators from London School of Hygiene and Tropical Medicine also helped the team in thinking through the TOC.
- Enumeration of high schools in Bijapur and Bagalkot

An enumeration of high schools and high school students in Bijapur and Bagalkot

districts was conducted to build the evidence for the project. This information was also used to develop randomized clusters for interventions and control. The study was done as part of STRIVE initiative. The high school enumeration was designed

- to collect information of total students enrolled in 8th , 9th and 10th standards as per school records by sex and caste (SC/ST) for the current academic year and previous year.
- to collect details of teachers and school development and monitoring committees.
- to get an overview of information about the school infrastructure, schemes and other services offered by the schools.

A total of 1075 high schools were enumerated in 1283 villages and 18 towns.
The findings of the enumeration gave information on the percentage of high schools, average number of students in urban and rural high schools, funding of the schools, percentage of SC/ST girls enrolled, percentage of SC/ST girls enrolled in urban and rural high schools, percentage of SC/ST girls and boys enrolled in 10th standard than 8th standard in the district of Bagalkot, student- teacher ratio, infrastructural facilities, girls to boys ratio, etc.

Based on this enumeration, 34 intervention clusters consisting of 121villages, 54 high schools and 118 higher primary schools were selected for intervention in Bijapur and Bagalkot Districts. In addition, this enumeration also helped in selecting 34 clusters as control clusters which included 123 villages, 50 high schools and 91 higher primary schools.

- Enumeration of Higher Primary Schools and Adolescent Girls who completed 7th Standard

For the purpose of establishing a baseline for rates of enrolment at the beginning of the project, enumeration of higher primary schools and enumeration of girls who had completed 7th standard was undertaken. This was done by visiting the higher primary schools in intervention and control clusters by the project field staff. This helped to establishing a baseline figure for those adolescent girls who were eligible to enter into formal secondary education.

List of girls studying in 7th standard and those who would appear for the 7th standard exams during the academic year 2012-13 was collected from 209 Higher Primary School (HPS) in intervention and control clusters. Details like full names, complete address, age, caste etc were collected.

This list collected from schools was then validated through a home visit process by the outreach workers. A total of 995 girls from Bagalkot and 856 girls from Bijapur

were enumerated. After the enumeration and validation the project gave each girl a unique id for tracking.

- Qualitative study to explore the factors that influence the retention and dropout of adolescent girls from educational institutions in northern Karnataka

The purpose of this study was to explore and analyse the structural factors that affect a girl to drop out from formal education in North Karnataka. The objective was also to understand how the different factors work in either causing the girl to drop out of schooling or cause her to continue education and what are the outcomes in the girls' life because of the decision to either drop out or retain in school.

This study was conducted in selected villages of Bagalkot and Bijapur districts where higher proportion of adolescent girls were missing from the households due to various reasons like child marriage, Devadasi sex work, migration and so on.

More than 50 in-depth interviews were completed in the two selected districts in Karnataka.

This study confirmed that gender norms and their respective gender expectations continue to exist in Northern Karnataka. Female children were not valued from birth and were given different household duties compared to boys. Child marriages were continuing to occur, however it was more hidden now. Negative health effects of child marriages were noted in the literature and were stated by the respondents. Education was found to be a positive influence in delaying the age of marriage for a girl and increasing her confidence and sense of agency.

- Parivartan Plus - Feasibility study

Under Sabala program one of the focus group for intervention was adolescent girls. Project focus was on strengthening the self-esteem and awareness of adolescent girls to enable them to make informed choices and empower them to collectively confront and overcome the issues they face. Hence, under Sabala program the strategy to conduct group sessions with adolescent girls using Parivartan modules was adopted to recognize and examine manifestations of gender disparity and gender-based violence, and empower girls to call for equality and their rights, especially their rights to education and freedom from discrimination. In Parivartan model developed by ICRW, sports were used as a medium to communicate the messages of gender, sexuality and vulnerabilities. As this model was implemented in an urban setting, a feasibility study was conducted in Bagalkot and Bijapur to test its relevance and applicability in rural context where Sabala was being implemented.

The findings of the study were

- Gender disparities posed significant barriers for the future of girls, education and marriage of girls.
- Sports were mentioned as a prominent part of the lifestyle in the villages.
- There was a difference in type of sports that are picked by the boys and girls.
- Presence of role model or mentors for boys and girls in the community.

3.5.2.3. Workshops, meetings and capacity building sessions

- Learning lab on 'Meeting the diverse HIV prevention needs of sex workers: Insights from the Karnataka Health Promotion Trust' was held on 16th Oct'2012. The meeting was led by Parinita Bhattacharjee from KHPT. It discussed the evolution of KHPT's programming with FSWs from a largely biomedical to an integrated structural approach that deals with stigma, violence, collectivisation and building an enabling environment for female sex workers. Other topics that were discussed were inadequacy of the revised strategies in dealing with intimate partner violence, gender power issues, and programme's ability to reach young sex workers early in their entry in sex work. Further, KHPT was able to use the theory of change thinking and monitoring and evaluation to work on these issues under the STRIVE consortium was also elaborated upon.
- Lori Heise (LSHTM) led discussions on understanding violence and oriented the team on looking at violence through the gender lens. Working with the family of adolescent girls and peers, including boys, was also done for the first time as part of Sabala.
- Lori Heise and Annie Holmes (LSHTM) organised two workshops with the KHPT team to detail out the intervention design of the two projects. The theory of change (TOC) tool was introduced and staff trained on the tool for project planning.
- Charlotte Watts, James Hargreaves and Calum Davey (LSHTM STRIVE team) on various occasions supported the KHPT team to design the evaluation for both the projects using the Randomised Control Trial (RCT) method. These capacity building sessions were held through video conferencing and Skype.
- Various webinars and labs on new areas in research, intervention strategies, documentation and emerging areas like transactional sex (especially among adolescents) and differences with sex work; and previously non prioritised areas like alcohol use were organised.
- The knowledge into action work had helped place an influence strategy at the very beginning of an intervention itself rather than at the end. Capacity was built in developing an influence strategy that is intertwined with the intervention.

- In addition to these, ICRW provided technical assistance in gender mainstreaming within the organisation (a) to build capacities of the program team at KHPT to integrate gender into their existing work, and (b) to help develop at least one tool kit for program managers to integrate gender into HIV prevention work. A workshop was organised in two phases on Mar' 15th to 18th, 2012 and August 27th to August 30th, 2012. In the first phase, gender, gender analysis and related topics were discussed and in the second part outcomes from the gender analysis to the programme was discussed.
- The qualitative research group in University of Manitoba was engaged in building the capacity of the team on qualitative research. Prakash Javalkar, Manager, Monitoring and Evaluation, KHPT attended the 'Social Science Workshop: Special Focus on Violence and Stigma' facilitated by Dr.Robert Lorway and Dr.Shamshad Khan from the University of Manitoba. The workshop focused on qualitative research skills such as conducting literature review and composing research and proposal methodology. Mr. Mahesh Doddamane, Senior Regional Manager, KHPT attended the three gender mainstreaming workshops facilitated by ICRW.

3.5.2.5. Other work

- The meetings and discussions at the state, district and block level with the Department of Education, Judiciary, Police (Department of Home), and Department of Women and Child Development were fruitful. We had sought and received approvals and support from these agencies for conducting research in the intervention and control areas. We had also received oral support for implementation of the intervention.

3.5.3. Lesson learnt

- Community consultation should form an integral part of any intervention design. A series of meetings and workshops conducted at the start of Samvedana plus and Sabala programmes helped in understanding community perspectives, formulating appropriate strategies, and for revision and modification of existing strategies.
- Formative research should be undertaken for a deeper understanding of the issues being addressed through the interventions. Interventions under Samvedana plus and Sabala were focused on addressing the structural reasons for violence against FSWs and school drop-out and early initiation of adolescent girls into sex work. Formative research helped to bridge the knowledge gap around structural drivers of these issues, and helped the intervention design be more effective. Often, government investments in interventions fall short of achieving the expected outcomes as the programme design was unable to identify and address

the structural factors abetting these issues. In this respect, formative research will aid in conceiving and planning for a comprehensive intervention that can take care of the varied dimensions of an issue.

3.6. Understanding the Sexual & Reproductive Health (SRH) needs of female sex workers (FSWs) & factors determining their access to services- supported by ICMR

3.6.1. About the study

The Indian response to the HIV epidemic has been broadly focused on HIV prevention among "most at risk populations" the majority of the are FSWs. In this "targeted" approach the emphasis is on detection and treatment of STIs including HIV.

Though FSWs are at a higher risk to STI/HIV due to "occupational exposure", it is largely overlooked that they are essentially women with SRH health needs too. In these programmes the health requirements of FSWs related to menstruation, contraception, pregnancy, abortions and menopause are inadequately addressed. Women have a basic right to SRH care irrespective of the profession they are in. The study aimed to explore various dimensions of SRH related to FSWs from their own perspectives.

This study also aimed at identifying areas/issues/gaps which could guide policy makers and programmers in framing programme guidelines which are in line with the community needs and perspectives, and most importantly are community friendly.

The objectives of the study are mentioned below

- To understand the SRH needs of FSWs from their perspectives.
- To study the pattern of common SRH ailments/issues faced by FSWs.
- To understand the factors/behaviours determining the uptake of SRH services by FSWs.

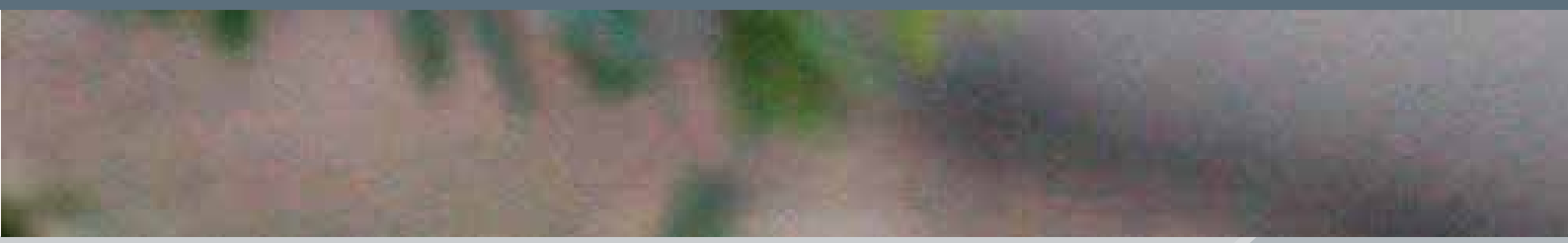
The project duration was planned for Jul'2012 to Nov'2013. This study was conducted with 500 FSWs in urban and rural Solapur. The methodology includes face to face interviews, Focus Group Discussions (FGD), Polling Booth Surveys (PBS) and pap smear screening.

3.6.2. Achievements (Jul' 2012 to Mar' 2013):

- Tool development workshop: This workshop was conducted in Solapur in Sept'12. Along with KHPT, NAD and KMS, 15 participants from the community participated in this workshop. A basic tool was worked out in this workshop.

- Review of the tool by the community members: After refinement the tool, it was again shared with the community members in Oct' 2012. Their suggestions were incorporated and the tool for pilot testing was ready by Nov' 2012.
- Pilot testing of the tool: In Nov' 2012 the tool was tested in the field. Community members participated in this exercise. Many points that emerged through the pilot testing were further refined and the final draft of the tool was shared with the Institutional Review Board (IRB) for their final approval.
- Finalisation of clinical examination and cancer screening protocols: Clinical examination and cancer screening were major component of this study. Nargis Dutt Memorial Cancer Hospital-Barshi, a World Health Organisation (WHO) collaborating centre for cancer research was identified for this activity. KHPT, NAD and Kranti Mahila Sangha (KMS) representatives visited the centre twice for finalizing the further course of action.

Section 4
Gender management



Section 4 Gender Management

The committee of 'Gender Integration and Committee against Sexual Harassment (GI-CASH)' in the year 2012 – 2013 conducted activities to strengthen the capacity of the senior staff to integrate gender into the projects/programs which were being implemented at KHPT.

KHPT partnered with International Centre of Research on Women (ICRW) – New Delhi to conduct structured levels of trainings at Bangalore for the senior programme staff. The first level training was to understand gender and its surrounding issues on cultural practices, patriarchy, and influences of the population on gender inequality. With this gender lens, the programme staff were given the task to look into the present ongoing programmes and explore the gender components that could be integrated.

Sessions on gender sensitivity to gender transformation were added in the newly developed training manuals of some of the projects of KHPT.

The Gender Integration and Committee against Sexual Harassment had made it mandatory to add a session on the "sexual harassment policy and details about the committee' in the induction training for the new recruits. The sessions also stress on maintaining confidentiality of the complainant and the procedures involved.

The committee stringently addressed complaints which were received.
In the coming year, the committee will add new members from zonal and central offices.

Section 5
Partnerships

Section 5 Partnerships

The various organizations that KHPT partners with are:

1. Donors
   - AVAHAN- India AIDS Initiative of Bill and Melinda Gates Foundation
   - Abt Associates Incorporation
   - DFID through London School of Hygiene and Tropical Medicine
   - Government of Karnataka
   - NACO, KSAPS, MSACS
   - United Nations Trust Fund
   - United States Agency for International Development
   - World Bank
   - World Health Organization

2. Affiliate Partner
   - Centre for Global Public Health
   - India Health Action Trust (IHAT)
   - Indian Council of Medical Research (ICMR)
   - Karnataka State AIDS Prevention Society (KSAPS)
   - Maharashtra State AIDS Control Society (MSACS)
   - National AIDS Control Organization(NACO)
   - Public Health Foundation of India(PFHI)
   - State Health Resource Training Centre
   - University of Laval (CHA)
   - University of Manitoba (UoM)

3. Technical Partners
   - CBCI Society for Medical Education, St. Johns Medical College, Bangalore
   - Centre For Advocacy and Research
   - International Centre for Research on Women (ICRW)
   - Intra Health
   - Karnataka Judicial Academy
   - Karuna Trust
   - National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore
   - National Law School of India University, Bangalore
   - Rajiv Gandhi University of Health Sciences
   - State Health Resource Training Centre

- Centre for Global Public Health
- Social and Mathematical Epidemiological Group , London School of Hygiene and Tropical Medical Science (LSHTM)

Table 5.1: Implementing partners

	Organization	District
A. Organizations-Karnataka	Accept Society Blesson Philip	Bangalore
	Adolescent Education Programme of Government of Karnataka	
	Ashakiran Charitable Trust	Mysore
	Assissi Society of Assisi Sisters of Mary Immaculate	Raichur
	Basava Seva Trust	
	Belgaum Integrated Rural Development Society (BIRDS)	Bangalore
	CCOORR [Christian Council for Rural Development and Research]	Uttara Kannada, Dakshina Kannada, Shimoga
	Chaitanya Rural Development Society	Chitradurga, Haveri
	Citizens Alliance for Rural Development and Training Society, CARDTS	Tumkur
	Department of State Educational Research and Training (DSERT), Karnataka	
	Dhwani Institute for Rural Development	Mandya, Gadag
	Government College of Teachers' Education (CTE)	Jamkhandi
	Health Education Empowerment Rehabilitation Association	Haveri
	Hemophilia Society	Davanagere
	Institute for Advanced Studies in Education (IASE),	Gulbarga
	Institute for Youth and Development	Kolar

	Organization	District
A. Organizations-Karnatak	Karwar Diocesan Development Council	Uttar Kannada
	Moogambikai Charitable and Education Trust	Ramanagara
	ORBIT (Organisation of Bidar Integral Transformation)	Bidar
	Our Lady Of Mercy S.A.B Trust	Kolar
	Payana	Bangalore
	Sadhane	Bangalore
	Samraksha	Koppal
	Samuha	Gadag
	Shanthinilaya Community Health Care Centre	Bangalore
	Shantiniketan Charitable Society	Shimoga
	Sneha Charitable Trust	Bangalore, DK
	Society for People's Action for Development (SPAD)	Dharwad
	Society of St. Mary's Hospital	Bellary
	Society of the Sisters of St. Joseph's of Tarbes	Bijapur
	Society of the sisters of the Holy Cross	Chikmanglur, Chamarajanagar
	Sri Sai International Charitable Trust	Chikballapur
	St. Gregorios Dayabhavan	Tumkur
	St. Luke Medical Society	Gulbarga
	Sumanahalli	Bangalore, Belgaum
	Swami Vivekananda Youth Movement	Mysore
	The Provincial Congregation of the sisters of St. Charles Borromeo	Belgaum

	Organization	District
B. CBOs-Karnataka	AIDS Jagruthi Mahila Sangha	Bijapur
	Belaku Mahila Sangha	Dharwad
	Belaku Mahila Okkuta	Raichur
	Belaku Soukhya Samriddhi	Bellary
	Chaitanya AIDS Tadegattuva Sangha	Bagalkote
	Durga Shakthi AIDS Tadegattuva Sangha	Davangere
	Jeevan Jyothi Mahila Abhibrudhi Samaste	Gulbarga
	Jeevanjyoti Soukya Samrudhi	Gulbarga
	Kranthi Mahila Sangha	Uttar Kannada
	Milana Sangha	Bagalkot
	Nava Spoorthi Sangh	Bijapur
	Ondugudu Mahila Sangha	Tumkur
	Rakshana Mahila Sangha	Gadag
	Sadhana AIDS Tadegattuva Mahila Sangha	Shimoga
	Shakti AIDS Tadegattuva Sangha	Belgaum
	Soukhya Belaku Samudaya Seva Samaste	Bellary
	Soukhya Samudaya Samasthe	Chitradurga
	Soukhya Sanjeevni Samasthe	Chickballapur
	Soukhta Samrudhi Samasthe	Kolar
	Soukya Samriddhi Mahila Sangha	Chitradurga, Bellary
	Spandana Mahila Sangha	Haveri
	Swati Mahila Sangha	Bangalore
	Sweekar Sangha	Belgaum
	Vijaya Mahila Sangha	Bangalore
	Vimukthi AIDS Tadegattuva Sangha	Bellary

	Organization	District
C. Organisations-Maharastra	Bel Air Hospital	Satara
	Dhanvantari Vaidyakiya Chikitsa Pratishthan	Nanded
	Dhanvantris Organisation For Socio-health Transformation	Hingoli
	Diocese of Chanda Society	Chandrapur
	Drushti Bahu-uddeshiya Sanstha	Gondia
	Eduljee Framjee Allbless Niramay Niketan	Mumbai
	G.M. Priya Health and Development Society	Latur
	Gandhi Memorial Leprosy Foundation	Wardha
	Jai Laxmi Shikshan Sanstha	Bhandara
	Jay Samka Kalyani Sanstha	Washim
	Jeevan Vikas Sanstha	Amaravati
	Jyothis Charitable Trust	Raigad
	Karunalaya Trust	Pune
	KJ Somaiya Medical Trust	Mumbai
	Late Shriram Ahirrao Memorial Trust	Dhule
	Late Shriram Ahirrao Memorial Trust	Nandurbar
	Lotus Medical Foundation	Kolhapur
	Manavya- children CCC	Pune
	Nav Yuvak Gram Sudhar Samiti	Gadchiroli
	Niramay Arogya Dham	Solapur
	PRIDE INDIA	Osmanabad
	Priyadarshini Rural Upliftment Society	Akola
	Sai Prem Gramin Vikas Sanstha	Yavatmal

	Sangli Mission Society	Sangli
	Sangli Mission Society	Ratnagiri
	Shanti Mandal	Aurangabad
	Snehalaya	Ahmednagar
	Social Activities Integration	Thane
	St. Joseph Educational and Medical Relief Society	Nashik
	Vanchit Vikas	Pune
	YUVA Rural Association	Buldhana

Section 6

Senior Management

Section 6 Senior Management

KHPT's Senior Management Team consists of highly experienced professionals.

Mr. Arkajyothi Samanta, Director, Human Resources (HR) has extensive experience in human resources management with a background of working in public sector undertaking and NGOs. He is a life member of National Institute of Personnel Management, India.

Mr. Ashokanand H.S, Director, Advocacy, KHPT is a Senior Indian Administrative Service (IAS) officer graduated from State Civil Service Cadre. He has over two decades of experience of working on various developmental issues like watershed management, disaster management, education, human resource and capacity building, social welfare (SC and ST welfare) and health (HIV/AIDS and related areas). His expertise lies in the area of empowerment of Panchayati Raj Institutions. . As Director-Advocacy, he has successfully mainstreamed HIV related issues with various Government Departments like Women and Child Welfare, Education, Housing, Food and Civil Supply, Law and Justice, Police, Social Welfare, Health etc. He was instrumental in establishing and successfully operationalising the satellite Communication Centre in the State Institute of Rural Development (ANS SIRD, Mysore) as the Astral Director.He has been a member of various expert committees both at the State and the National level. Currently he is a member of Quality Monitoring Group in the Department of Planning guiding and monitoring the preparation of Human Development Report for the State of Karnataka. And he is a member of the advisory committee of Karnataka Evaluation Authority, Government of Karnataka. He has worked as Director, State Institute of Rural Development, Mysore. He has a master degree in Plant Science and also a PG Diploma in Environment Planning from the University of Mysore.

Dr. James Blanchard is an epidemiologist and public health specialist focusing on global health. He is a Professor in the Departments of Community Health Sciences and Medical Microbiology and Director of the University of Manitoba's Centre for Global Public Health. He is a Canada Research Chair in Epidemiology and Global Public Health. Over the past ten years, Dr. Blanchard has led extensive research and public health program development related to HIV/AIDS and maternal and child health in India, other Asian countries and Africa. His research focuses on how the characteristics of individuals, communities, and large populations contribute to the local and global distribution of communicable and non-communicable diseases.

Building on this knowledge, he works with policy makers and public health leaders to develop and implement effective public health strategies for disease prevention. Dr. Blanchard received his MD from the University of Manitoba and his MPH and PhD in Epidemiology from the Johns Hopkins University.

Mr Mohan HL, Director, Community Mobilisation and Communications, is a social scientist. He has spent more than two decades working in government and non-governmental sectors, especially in the areas of education, health, decentralization and adolescent education. During his tenure he has designed programmes for community empowerment and for the front line workers. He has worked extensively with the grass-roots communities, using information and communications technology for empowering community members. Mr. Mohan has worked as a consultant for development projects in India and other countries, with United Nations Population Fund (UNFPA), United Nation Educational, Scientific and Cultural Organisation (UNESCO) and United Nations Children's Fund (UNICEF). He has developed, implemented and managed several communications campaigns, and leads KHPT's communication and community intervention initiatives. Mr. Mohan earned a Master's degree in Rural and Urban Development, from the School of Social Work, Roshni Nilaya, Mangalore and has a Diploma in Programme Management and Communication.

Dr Mrunal Shetye, Project Director, KHPT GFATM- 6 CCC project, has an extensive experience in the field of public health. Before joining KHPT, Dr. Shetye worked as surveillance medical officer with the National Polio Eradication Programme and as a physician and research officer with the National AIDS Research Institute, Pune. He is a member of the National Technical Resource Group on Care, and has played a lead role in the developing national guidelines for Community Care Centres (CCC) and reworking the M and E system. He has provided major contributions to the assessment of the CCC programme nationally. He has worked extensively in the design, roll-out, scale-up and monitoring of HIV prevention interventions and medical service delivery for Female Sex Workers (FSW) and Men having Sex with Men (MSM). He received his M.D. from B. J. Medical College, University of Pune.

Ms. Parinita Bhattacharjee, Senior Technical Advisor, HIV prevention for University of Manitoba-Africa programme has more than eighteen years of extensive experience in designing and managing programmes for sexual health, HIV prevention and care. Her work includes providing technical support to Government of Kenya to scale up HIV prevention programmes with key populations and enhance the impact of HIV prevention programmes in the country. Her previous work experience is in the area of scaling up HIV prevention interventions with sex workers, men who have sex with men and transgender populations in Karnataka, India. Previosly as Director –

Programmes in Karnataka Health Promotion Trust, Bangalore, India, she contributed significantly to different projects of the organisation. She also provided support to Karnataka SACS in scaling up target interventions in state and was member of the Technical Working Group of NACO to scale up the Link Worker Scheme. A strong believer in planning with the community, she has developed participatory tools on sexual health and has provided technical support to Bhutan, Sri Lanka and Ethiopia to design, scale up and evaluate their HIV prevention interventions. She has authored journal articles, strategy papers, reports and project related training manuals. Ms. Bhattacharjee received a Master's in Medical and Psychiatric Social Work from Tata Institute of Social Sciences, Mumbai.

Dr. Priyamvada Singh, State Head Rajasthan and Trustee, Indian Health Action Trust(IHAT), is a development professional with twenty seven years of demonstrated experience and commitment in addressing the societal inequalities particularly, concerning women and children' health, education and development. She is a Developmental Consultant with University of Manitoba and is heading UoM-IHAT program team in Rajasthan. She is a self made person and sets high standards of professional and human dignity. She has been passionately involved in developing and managing innovative education, health and HIV-AIDS programmes for the neediest populations and has worked closely with the International Development Aid Agencies, CSOs, community structures and the Government systems. She has worked for Swedish International Developmental Agency (SIDA) and Department of International Development (DFID) funded prestigious Education for All project "Lok Jumbish", 'Girls Primary Education' project of CARE, Maternal and Child Health projects supported by Parivar Seva Sansatha (PSS), SCBR and the Life Skill Based Education and Link Worker Schemes projects funded by the UNICEF. Dr. Singh had been a member of NACO's Technical Resource Group on Targeted Interventions, NACP-III. Dr. Singh has authored several publications on education and HIV-AIDS. She received her Ph.D. from University of Rajasthan, Jaipur. She has a background in the social sciences, holding PhD, LLB, MBA and Master Degrees in History and in Philosophy.

Dr Ramesh BM, Director, Monitoring & Evaluation, has a PhD in Demography and is a former faculty member of the International Institute for Population Sciences, Mumbai. Prior to joining KHPT, Dr. Ramesh was the Director of the Population Research Centre, Dharwad. He has more than 20 years of experience in monitoring and evaluation of health programs including HIV/AIDS interventions. He has vast research experience in the fields of demography, reproductive health, HIV/AIDS. Recently, he has also taken up the positions that lead large scale maternal, newborn and child health (MNCH) projects. His main areas of interest are management information systems,

MNCH and HIV/AIDS programmes. He was a coordinator of the first round of the National Family Health Survey—one of the largest household surveys in the country. While at the International Institute for Population Sciences, he taught research methodology, population structure and characteristics, population education, and population psychology, and completed several research studies. While director of the Population Research Centre, Dr. Ramesh performed programme evaluations, implemented a reproductive health programme in the district, and developed a management information system for that programme. He was a recipient of a Population Council postdoctoral fellowship in 1996. Dr. Ramesh received his Ph.D. from Mumbai University.

Dr. Reynold Washington, Managing Trustee, KHPT is a Community Health Specialist with over two decades of teaching, programmatic and research experience. His special areas of interest include HIV, TB and Maternal, Neonatal and Child Health. He is recognized for his leadership in scaling up HIV prevention and care services, training systems and research across Karnataka and other states in India, for pioneering innovations that significantly contributed to the national program and public policy, and for translating knowledge to post-graduate students, program implementers, policy makers and donors in India and several countries in Africa and Asia. He has more than thirty publications in peer reviewed journals and 100 papers presented at national and international conferences. He is a technical resource member for the World Health Organisation (WHO), the Indian Council of Medical Research (ICMR), the National AIDS Control Organisation (NACO) and the Karnataka State TB Operations Research Committee. Dr. Reynold completed his MBBS, MD- Community Health and DNB (Social & Preventive Medicine) at St John's Medical College in Bangalore. He holds adjunct faculty positions with St John's Research Institute and the Department of Community Health Sciences, University of Manitoba.

Mr. Senthil Murugan, Director, Strategic Initiatives & Knowledge Translation at KHPT/ University of Manitoba, is a social scientist with extensive work experience with UN agencies and different funding and implementing agencies. He leads the learning and sharing initiatives, including the Karnataka State AIDS Prevention Society's Technical Support Unit. Mr. Murugan has developed national policies and strategies to reach vulnerable groups, studied the socio-economic condition of female sex workers and their children, and managed HIV prevention programmes in Kerala, Karnataka and Tamil Nadu. He also has valuable and commendable experience of working with grass roots communities, especially with those who are most at risk of acquiring and transmitting HIV infection. Mr. Murugan has a professional association with the University of Manitoba, Canada. Mr. Murugan earned a Master's degree in Social Work from Madras School of Social Work, Madras University.

Dr. Shajy Isac, Senior Technical Advisor, Monitoring and Evaluation at the Centre for Global Public Health, University of Manitoba has over fifteen years of extensive experience as a demographer in monitoring and evaluation in the areas of HIV/AIDS, Health, Maternal and Child Health (MCH), Reproductive and Child Health (RCH), Education etc. In his current role, he provides technical support for HIV/AIDS epidemic appraisal and developing a monitoring and evaluation strategies for the HIV/AIDS programs in various countries in Asia, Africa and Europe. Presently, he is leading the University of Manitoba's India research team. He has led many mapping and research surveys globally in the field of HIV/AIDS, including South Asia and Africa. He is a member of various technical expert groups in the field of HIV/AIDS intervention programs. He has provided expertise in designing large scale surveys of HIV/AIDS, Health, MCH, education, etc including sampling and survey methods. He has handled number of studies for various international and national donors including UNICEF, World Bank, WHO, United Nations Population Fund (UNFPA), United States Aid for International Development (USAID), Research Triangular Institute (RTI), Department of International Development, UK (DFID), etc. and for the Ministry of Health & Family Welfare (MHFW), Government of India (GoI) and various state governments. He has authored more than thirty five papers and has mentored research students from India and abroad. He received his PhD. from International Institute of Population Sciences, Mumbai.

Dr. Srinath Maddur, Director, Capacity Building, is a psychologist, and has more than 15 years of experience in the field of HIV & AIDS. He has worked extensively with exploited children and people living with HIV, and has strong interest in public health applications of information & communication technology. He leads capacity building initiatives and has developed, implemented & managed several capacity building strategies. He received his Ph.D. in psychology from Bangalore University.

Dr. Stephen Moses, Project Director, Sankalp, is a physician and public health specialist who has spent over 25 years applying the discoveries and methods of medical science to public health programming and policy globally. He has pioneered HIV prevention programmes in Kenya and India, has forged institutional alliances for international scientific collaboration, and has led research programmes throughout Asia and Africa. Dr. Moses is a professor of Community Health Sciences at the University of Manitoba and is country director for the University's HIV and AIDS programmes in India. His main research and programmatic interests include biological and behavioural risk factors for STI/HIV transmission; syndromic approaches and risk assessment in the management of STIs; targeted interventions to reduce the transmission of STIs and HIV infection; health worker training in STI management in resource-poor settings;

and integrated approaches to STI/HIV prevention and control. Dr. Moses has an MD from the University of Toronto and an MPH from the Johns Hopkins University.

Mr. Sukathirtha HS Senior Technical Advisor Finance and Administration, has more than thirty three of experience in finance out of which around twenty seven years experience in managing the finances of international funding agencies/ NGOs working in integrated rural development and specifically last nine years health sector in India. Sukathirtha will provide overall leadership to financial management, internal audit of the Trust funded projects including other technical support to the specific projects in the Country for University of Manitoba affiliated projects in India. He is a post graduate in finance and has other relevant specialization courses from different universities/institutions.

Section 7

Abstracts and Publications

Section 7 Abstracts and Publications

7.1. University of Manitoba and KHPT-IHAT Conference Abstracts, 2012-13

- Pediatric Academic Societies' Annual Meeting 2012, Boston Massachusetts, April 28-May 1, 2012
  - Crockett M, Avery L, Ramesh BM, Jayanna K, Moses S, Blanchard J. Assessment and management of children with severe diarrhea in Karnataka, India [Abstract 753679].
- XIX International AIDS Conference, Washington, DC, July 22-27, 2012
  - Mehta S, Li H, Moses S, Agot K, Maclean I, Hedeker D, Bailey R. The efficacy of medical male circumcision against HIV acquisition at 66 months post-procedure in Kisumu, Kenya [Abstract TUAC0402].
  - Mitchell KM, Foss AM, Prudden HJ, Pickles M, Williams JR, Johnson HC, Ramesh BM, Washington R, Isac S, Rajaram S, Phillips AE, Bradley J, Alary M, Moses S, Lowndes CM, Watts CH, Boily MC, Vickerman P. Sexual mixing patterns between men who have sex with men in southern India: implications for modelling the HIV epidemic and predicting the impact of targeted oral pre-exposure prophylaxis [Abstract THPDC0101].
  - Prudden HJ, Foss AM, Mitchell KM, Pickles M, Ramesh B, Washington R, Phillips AE, Isac S, Rajaram S, Lorway R, Bradley J, Moses S, Alary M, Boily MC, Watts CH, Lowndes CM, Vickerman PT. Using mathematical modelling to improve our understanding of the HIV prevalence among the 'hidden' population of men who have sex with men (MSM) in southern India: implications for HIV programming [Abstract MOPE135].
  - Shaw SY, Isac S, Washington RG, Deering KN, Ramesh BM, Blanchard JF, Moses S. HIV prevalence and risk behaviour profiles of migrant clients of female sex workers in Karnataka, south India [Abstract MOPE245].
  - Thamattoor U, Thomas TS, Banandur P, Rajaram S, Mahajan U, Mainkar M, Paranjape R, Ramakrishnan L, Adhikary R, Washington R, Isac S, Ramesh BM, Moses S, Alary M. Factors affecting HIV testing among female sex workers in 24 districts of southern India: a multilevel modelling analysis [Abstract MOPE248].

- Prudden HJ, Mitchell KM, Phillips AE, Pickles M, Ramesh B, Washington R, Isac S, Rajaram S, Bradley J, Lorway R, Alary M, Moses S, Watts CH, Vickerman PT, Lowndes CM, Boily MC, Foss AE. Do men who have sex with men (MSM) in southern India change their identity or sexual role behaviour over time? Implications for the HIV epidemic [Abstract MOPE285].
- Shaw SY, Becker M, Prakash J, Ramesh BM, Isac S, Blanchard JF, Moses S, Washington RG. Tuberculosis infections among persons living with HIV in Karnataka state, southern India: a population-based analysis [Abstract TUPE125].
- Alary M, Banandur P, Potty RS, Mahajan U, Thammattoor UK, Thomas T, Mainkar M, Paranjape R, Adhikary R, Duchesne T, Ramesh BM, Isac S, Moses S. Multilevel analysis of the trends in HIV prevalence among female sex workers (FSWs) in 24 districts of south India: role of program factors and contextual variables [Abstract WEPE108].
- Kumar DRS, Isac S, Halli SS, Krishnan S, Brooks A, Bharat S, Raviprakash R, Javalkar P, Washington R, Moses S. HIV risk among female sex workers using cell phones for solicitation in Karnataka state, south India: implications for HIV prevention [Abstract TUPE329].
- Banandur SP, Potty RS, Mahajan U, Thammattoor UK, Thomas T, Mainkar M, Paranjape R, Adhikary R, Duchesne T, Banadakoppa RM, Isac S, Moses S, Alary M. Do intensive HIV prevention programs affect the time trends inconsistent condom usage among female sex workers in south India? Multilevel modeling analysis of serial cross sectional surveys in 24 districts [Abstract TUPE333].
- Banandur SP, Potty RS, Mahajan U, Thammattoor UK, Thomas T, Mainkar M, Paranjape R, Adhikary R, Duchesne T, Banadakoppa RM, Isac S, Moses S, Alary M. Multilevel modeling analysis of Individual, programmatic and contextual factors affecting time trends in syphilis among female sex workers (FSWs) from 24 districts of south India [Abstract TUPE337].
- Isac SK, Prakash R, Ramesh BM, Bhattacharjee P, Washington R, Blanchard J, Moses S. Challenges in increasing condom use among female sex workers with their regular sex partners in Karnataka state, south India [Abstract TUPE355].
- Washington R, Isac S, Banandur P, Becker M, Garadys L, Rajaram R, Shivahalli S, Auroville B, Moses S, Ramesh BM. A longitudinal study on quality of life of people living with HIV in Karnataka, south India [Abstract MOPE418].
- Halli SS, Bhattacharjee P, Washington R, Ramnaik S, Raghavendra T, Blanchard J, Moses S. Persistent STIs leading to hysterectomy among young female sex workers in Karnataka, south India [Abstract MOPE671].
- Sabnis V, Shetti B, Sandeep H, Kulkarni G, Bhattacharjee P, Moses S. Community participation towards sustainability of health intervention initiatives: an

inclusive approach of rural intervention programme, Karnataka, India [Abstract MOPE545].

- Isac SK, Dorjee G, Ramesh BM, Lorway R, Bradley J, Moses S, Blanchard J. Concurrent sexual partnerships and high risk sexual networks in Bhutan: implications for HIV transmission [Abstract TUPE630].
- Bhattacharjee P, Raghavendra T, Doddamane M, Sudheer C, Murugan SK, Narayana S, Blanchard J, Moses S. Across state borders: reaching migrant female sex workers with HIV prevention programs and services across the Karnataka, Maharashtra border in south India [Abstract THPE198].
- Suresh M, Bhattacharjee P, Isac S, Moses S. Changing typology of female sex work in Karnataka, south India: implications for programs [Abstract THPE256].
- Beattie TS, Bhattacharjee P, Mohan HL, Chandrashekar S, Suresh M, Rao D, Isac S, Heise L, Ramesh BM, Moses S, Watts C. Exposure to community mobilisation is associated with increased power, increased service use, increased condom use and lower HIV and STI prevalence among female sex workers in Bellary district, south India [Abstract THPE275].
- Tharakan M, Rao R, Harnahalli Lakkappa M, Holla P, Bhattacharjee P, Moses S. Models of community mobilization among female sex workers within an empowerment framework: experiences from Karnataka, south India [Abstract THPE280].
- Deering K, Shaw S, Bhattacharjee P, Satyanarayana S, Raghavendra T, Doddamane M, Thompson L, Moses S, Lorway R. Physical and sexual violence by non-paying intimate partners against female sex workers in southern India [Abstract THPE412].

7.2. University of Manitoba and KHPT/IHAT Publications, 2012-2013

- Becker ML, Mishra S, Satyanarayana, Gurav K, Doshi M, Buzdugan R, Pise G, Halli S, Moses S, Avery L, Washington RG, Blanchard JF. Rates and Determinants of HIV-attributable mortality among rural female sex workers in northern Karnataka, India. Int J Sexually Transmitted Disease(STD) and AIDS 2012; 23:36-40.
- Reza-Paul S, Lorway R, O'Brien N, Lazarus L, Jain J, Bhagya M, Fathima MP, Venukumar KT, Raviprakash KN, Baer J, Steen R. Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore. Indian J Med Res 2012; 135:98-106.
- Mishra S, Sgaier SK, Thompson LH, Moses S, Ramesh BM, Alary M, Wilson

- D, Blanchard JF. HIV epidemic appraisals for assisting in the design of effective prevention programmes: shifting the paradigm back to basics. PLoS One 2012; 7(3):e32324.
- Bradley J, Rajaram SP, Moses S, Boily MC, Ramesh BM, Isac S, Lobo A, Gowda GC, Pushpalatha R, Gurav K, Kumar S, Washington R, Pickles M, Alary M. Why do condoms break? A study of female sex workers in Bangalore, south India. Sex Transm Inf 2012; 88:163-70.
- Shaw SY, Lorway RR, Deering KN, Avery L, Mohan HL, Bhattacharjee P, Reza-Paul S, Isac S, Ramesh BM, Washington R, Moses S, Blanchard JF. Factors associated with sexual violence against men who have sex with men and transgendered individuals in Karnataka, India. PLoS ONE 2012; 7(3):e31705.
- Dixon V, Reza-Paul S, D'Souza FM, O'Neil J, O'Brien N, Lorway R. Increasing access and ownership of clinical services at an HIV prevention project for sex workers in Mysore, India. Glob Public Health 2012; 7:770-791.
- Lowndes CM, Jayachandran AA, Banandur P, Ramesh BM, Washington R, Sangameshwar BM, Moses S, Blanchard J, Alary M. Polling booth surveys: a novel approach for reducing social desirability bias in HIV-related behavioural surveys in resource-poor settings. AIDS Behav 2012; 16:1054-62.
- Bradley J, Ramesh BM, Rajaram S, Lobo A, Gurav K, Isac S, Chandra Shekhar Gowda G, Pushpalatha R, Moses S, Sunil KD, Alary M. The feasibility of using mobile phone technology for sexual behaviour research in a population vulnerable to HIV: a prospective survey with female sex workers in south India. AIDS Care 2012; 24:695-703.
- Sgaier SK, Claeson M, Gilks C, Ramesh BM, Ghys PD, Wadhwani A, Ramakrishnan A, Tangri A, Chandramouli K. Knowing your HIV/AIDS epidemic and tailoring an effective response: how did India do it? Sex Transm Inf 2012; 88:240-9.
- Aubé-Maurice J, Clément M, Bradley J, Lowndes CM, Gurav K, Alary M. Gender relations and risks of HIV transmission in South India: the discourse of female sex workers' clients. Cult Health Sex 2012; 14:629-44.
- Beattie TS, Bhattacharjee P, Suresh M, Isac S, Ramesh BM, Moses S. Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. J Epidemiol Community Health 2012; 66:ii42-8.
- Banandur P, Ramnaik S, Manhart LE, Buzdugan R, Gurav K, Mahapatra B , Isac S, Halli SS, Washington RG, Moses S, Blanchard JF. Understanding out-migration among female sex workers in South India. Sex Transm Dis 2012; 39:776-83.
- Potty RS, Bradley JE, Ramesh BM, Isac S, Washington RG, Moses S, Blanchard JF, Becker ML, Alary M. Is HIV prevalence declining in southern India? Evidence from two rounds of general population surveys in Bagalkot district, Karnataka.

Sex Transm Dis 2012; 39:761-8.

- Mishra S, Ramanaik S, Blanchard JF, Halli S, Moses S, Raghavendra T, Bhattacharjee P, Lorway R, Becker M. Characterizing sexual histories of women before formal sex-work in south India from a cross-sectional survey: implications for HIV/STI prevention. Bio Med Central(BMC) Public Health 2012; 12:829.
- Buzdugan R, Halli SS, Hiremath JM, Jayanna K, Raghavendra T, Moses S, Blanchard J, Scambler G, Cowan. F. The female sex work industry in a district of India in the context of HIV prevention. AIDS Res Treat 2012; Article ID 371482, 10 pages.
- Becker M, Ramanaik S, Halli S, Blanchard JF, Raghavendra T, Bhattacharjee P, Moses S, Avery L, Mishra S. The intersection between sex work and reproductive health in northern Karnataka, India: identifying gaps and opportunities in the context of HIV prevention. AIDS Res Treat 2012; Article ID 842576, 9 pages.
- Jadhav A, Bhattacharjee P, Raghavendra T, Blanchard J, Moses S, Isac S, Halli SS. Risk behaviors among HIV-positive female sex workers in northern Karnataka, India. AIDS Res Treat 2013; Article ID 878151, 7 pages.
- Banandur P, Mahajan U, Potty RS, Isac S, Duchesne T, Abdous B, Ramesh BM, Moses S, Alary M. Population-level impact of Avahan in Karnataka state, south India using multilevel statistical modelling techniques. J Acquir Immune Defic Syndr 2013; 62:239-45.
- Deering KN, Bhattacharjee P, Mohan HL, Bradley J, Shannon K, Boily M-C, Ramesh BM, Isac S, Moses S, Blanchard J. Violence and HIV risk among female sex workers in southern India. Sex Transm Dis 2013; 42:168-74.
- Bradley J, Rajaram S, Moses S, Gowda GC, Pushpalatha R, Ramesh BM, Isac S, Boily MC, Lobo A, Gowda H, Alary M. Female sex worker client behaviors lead to condom breakage: a prospective telephone-based survey in Bangalore, south India. AIDS Behav 2013; 17:559-67.
- Deering KN, Vickerman P, Pickles M, Moses S, Blanchard JF, Ramesh BM, Isac S, Boily M-C. Differences between seven measures of self-reported numbers of clients of female sex workers in southern India: implications for individual- and population-level analysis. AIDS Behav 2013; 17:649-61.
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- Gurav K, Lorway R, Bradley J, Blanchard J. Role of Devadasi brothel madams in the promotion of safe sex practices among sex workers in the brothels of Maharashtra, India. Int J Sociol Anthropol 2013; 5:35-40.
- Shaw SY, Bhattacharjee B, Isac S, Deering KN, Ramesh BM, Washington R, Moses S, Blanchard JF. A cross-sectional study of sexually transmitted disease pathogen prevalence and condom use with commercial and non-commercial sex partners among clients of female sex workers in southern India. Sex Transm Dis 2013; 40:482-9.
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- Bhattacharjee P, Prakash R, Pillai P, Isac S, Haranahalli M, Blanchard A, Shahmanesh M, Blanchard J, Moses S. Understanding the role of peer group membership in reducing HIV-related risk and vulnerability among female sex workers in Karnataka, India. AIDS Care 2013; 25 (Suppl 1):46-54.
- Mahapatra B, Lowndes CM, Gurav K, Ramesh BM, Moses S, Washington R, Alary M. Degree and correlates of sexual mixing in female sex workers in Karnataka, India. Sex Health 2013; 10:305-10.
- Boily MC, Pickles M, Lowndes CM, Ramesh BM, Washington R, Moses S, Deering KN, Mitchell KM, Reza-Paul S, Blanchard J, Vassall A, Alary M, Vickerman P. Positive impact of a large-scale HIV prevention program among female sex workers and clients in South India. AIDS 2013; 27:1449-60.
- Pickles M, Boily M-C, Vickerman P, Lowndes CM, Moses S, Blanchard JF, Deering KN, Bradley J, Ramesh BM, Washington R, Adhikary R, Mainkar M, Paranjape RS, Alary M. Assessment of the population-level effectiveness of the Avahan HIV-prevention programme in South India: a preplanned, causal-pathway-based modelling analysis. Lancet Glob Health 2013; 1:e289-99.
- Jayaraman GC, Kumar S, Isac S, Javalkar P, Gowda PR, Raghunathan N, Gowda CS, Bhattacharjee P, Moses S, Blanchard JF. Demographic changes and trends in risk behaviours, HIV, and other sexually transmitted infections among female sex workers in Bangalore, India, involved in a focused HIV preventive intervention. Sex Transm Inf 2013; 89:635-41.
- Thompson LH, Khan S, du Plessis E, Lazarus L, Reza-Paul S, Hafeez Ur Rahman S., Pasha A., Lorway R. Beyond internalized stigma: daily moralities and subjectivity among self-identified kothis in Karnataka, South India. Cult Health Sex 2013; 15:1237-51.

Section 8

Financial Report

R. Venkatakrishnan & Associates
Chartered Accountants

INDEPENDENT AUDITOR'S REPORT

To
The Managing Trustee
Karnataka Health Promotion Trust
Bangalore

Report on the Financial Statements

We have audited the accompanying financial statements of **Karnataka Health Promotion Trust**, which comprise the Balance Sheet as at 31 March 2013 and Income & Expenditure account for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation of these financial statements that give a true and fair view of the financial position of the Trust. This responsibility includes the design, implementation and maintenance of internal controls relevant to the preparation and presentation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with the Standards on Auditing issued by the Institute of Chartered Accountants of India. Those Standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error.

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Head Office : Chennai Branch : Devanahalli, Hyderabad, Salem

Venkatakrishnan & Associates
artered Accountants

In making those risk assessments, the auditor considers internal controls relevant to the Trust's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of the accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion and to the best of our information and according to the explanations given to us, the financial statements give the information in the manner so required and give a true and fair view in conformity with the accounting principles generally accepted in India:

(i) in the case of the Balance Sheet, of the state of affairs of the Trust as at March 31, 2013;
(ii) in the case of the Income and Expenditure account, the excess of income over expenditure for the year ended on that date; and

For R. Venkatakrishnan & Associates
Chartered Accountants
FRN. 008572S

28/9/2013

R. Mohan
Partner
Membership No. : 203911

Place: Bangalore
Date:

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

Balance sheet as at 31st March, 2013 - Consolidated

Particulars	Schedule	31st March, 2013 (Rupees)	31st March, 2012 (Rupees)
I Sources of Funds			
1 Reserves			
Corpus fund	1	10,000	10,000
General Reserve	2	35,083,279	29,012,748
Grant Received in Advance	3	48,089,941	56,252,621
Total		83,183,220	85,275,369
II Application of Funds			
1 Current Assets, Loans and Advances			
Cash and Bank Balances	4	72,758,666	78,265,224
Loans and advances	5	15,358,840	14,530,203
Total		88,117,506	92,795,427
2 Less : Current liabilities and provisions			
Current Liabilities	6	4,421,818	4,092,769
Provisions	7	512,468	3,427,288
Total		4,934,286	7,520,057
Net current assets		83,183,220	85,275,371
Total		83,183,220	85,275,371

For Karnataka Health Promotion Trust

Dr. Reynold Washington
Managing Trustee

H.S. Shantiltha
Director Finance

Place: Bangalore
Date : 28-Sep-2013

As per our audit report of even date attached
For R. Venkatakrishnan & Associates
Chartered Accountants
Firm No. 008572S

28/9/2013

R. Mohan
Partner
Membership No. 203911

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

Statement of Income and Expenditure - Consolidated

Particulars	Schedule	For the year ended 31st March, 2013 (Rupees)	For the year ended 31st March, 2012 (Rupees)
Income			
Grants Received - Utilized	3	311,414,895	440,709,288
Interest Income	8	4,171,283	5,243,026
Donations Others		63,749	193,500
Refund of Bank Charges		-	113,222
Sale of Assets		3,480,935	147,599
Exchange Difference & Misc Income		1,957,183	-
Total		321,088,045	446,406,635
Expenditure			
Programme Expenses	9		
-Grants to NGO's		84,348,047	173,685,283
-Grants to NGO's in Kind		-	1,106,344
-Other Programme Expenses		92,249,442	121,620,880
-Training and Capacity Building Expenses		10,609,296	7,940,771
Personnel Expenses	10	77,925,920	87,447,200
Administrative and other expenses	11	49,884,810	47,304,776
Refund of Grant Funds	12	-	-
Total		315,017,515	439,105,253
Excess of Income over Expenditure transferred to General Reserve		6,070,530	7,301,381

For Karnataka Health Promotion Trust

Dr. Reynold Washington
Managing Trustee

H.S. Sathyatirtha
Director Finance

Place: Bangalore
Date : 28-Sep-2013

KARNATAKA HEALTH PROMOTION TRUST BANGALORE INDIA

As per our audit report of even date attached
For R. Venkatakrishnan & Associates
Chartered Accountants
Firm No. 008572S

28/9/2013

R. Mohan
Partner
Membership No. 203911

R. VENKATAKRISHNAN & ASSOCIATES BANGALORE CHARTERED ACCOUNTANTS

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

	As at 31st March, 2013 (Rupees)	As at 31st March, 2012 (Rupees)
Schedules forming part of the accounts -Consolidated		
Schedule 1: Corpus Fund		
Opening balance	10,000	10,000
	10,000	**10,000**
Schedule 2: General Reserve		
Opening balance	29,012,749	21,711,367
Add: Transferred from Income & Expenditure A/c	6,070,530	7,301,381
	35,083,279	**29,012,749**
Schedule 3: Grant Received in Advance		
Opening balance	56,252,621	150,301,076
Grants Received during the year		
University of Manitoba	155,167,106	192,399,710
PHFI	4,082,332	5,432,179
PSI Segmentation Study	5,869,036	8,410,934
WHO APW	-	1,154,320
LSHTM-RFC	7,343,388	4,948,450
CGT Srilanka	-	721,902
CGHDDH-Boston University	367,725	583,103
ICRW	551,197	-
LSHTM- Sudhashree	566,550	-
STRIVE	3,582,447	-
Karnataka State Aids Prevention Society - KSAPS	20,777,949	15,996,121
The Global Fund to Fight AIDS, Tuberculosis, and Mala	81,922,704	89,800,379
TN SACS	-	257,870
ICMR	4,642,158	6,170,504
KHSDRF	568,231	5,102,762
NRHM	1,528,846	2,628,204
GOK-GSPP	160,330	187,000
KHPT-UNDP II - Develp. Revised Mannual	-	848,700
MSACS-Unicef Workshop - CLHIV	-	476,948
WCD-Sabala	1,044,403	1,950,000
UN WOMEN	-	11,008,806
WCD-Special Care Programme	-	266,288
Maharashtra State Aids Control Society(MSACS)	16,019,698	-
James N Jacob- Project House Exeperses	969,048	-
	361,415,768	**498,645,256**
Less:		
Refund of Grant Funds		
Clinton Foundation	-	992,806
21-PHFI DAPCU	-	309,902
UNFPA	-	80,832
KSAPS-Yuvajagruthi Mela-Samastha Dists	-	166,375
KSAPS-Yuvajagruthi Mela-LWS Dists	-	133,432
Exchange Fluctuation Income transferred	1,910,931	-
Grant Utilized transferred to Income & Expenditure Account	311,414,895	440,709,288
	313,325,827	**442,392,635**
Grant Received in Advance	**48,089,941**	**56,252,621**

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

	As at 31st March, 2013 (Rupees)	As at 31st March, 2012 (Rupees)
Schedules forming part of the accounts - Consolidated		
Schedule 4: Cash and bank balances		
Cash in Hand	334,312	556,323
Balance with Schedule Banks		
- in savings accounts	72,424,354	77,522,266
- in deposit accounts	-	186,636
	72,758,666	**78,265,224**
Schedule 5: Loans and advances		
Advances recoverable in cash or in kind or for value to be received	10,075,534	6,738,430
TDS receivable	1,512,465	1,799,093
Deposits	3,770,840	5,992,680
	15,358,840	**14,530,203**
Schedule 6 : Current liabilities		
TDS payable	937,982	508,008
Sundry creditors	2,923,410	2,962,311
Other liabilities	560,425	622,450
	4,421,817	**4,092,769**
Schedule 7 : Provisions		
Accruals	512,468	3,427,288
	512,468	**3,427,288**

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

	As at 31st March, 2013 (Rupees)	As at 31st March, 2012 (Rupees)
Schedules forming part of the accounts - Consolidated		
Schedule 8: Interest Income		
Savings Bank Accounts	1,804,471	1,870,039
Fixed Deposits	2,366,812	3,305,634
Income Tax Department	-	67,352
	4,171,283	**5,243,026**
Schedule 9 : Programme Expenses		
-Grants to NGO's	84,348,047	173,685,283
-Grants to NGO's in Kind	-	1,106,344
-Other Programme Expenses	92,249,442	121,620,880
-Training and Capacity Building Expenses	10,609,296	7,940,771
	187,206,785	**304,353,277**
Schedule 10 : Personnel Expenses		
Salaries	40,884,212	47,345,593
PF Employers' Share	4,682,181	4,219,662
Leave Encashment	21,050	74,127
Leave Travel Allowance	2,272,319	2,680,445
Consultancy Charges	27,334,846	28,789,375
Recruitment Expenses	182,054	15,934
Gratuity	345,040	1,396,611
Insurance-Staff	2,163,891	2,803,178
Ex-Gratia	40,327	122,276
	77,925,920	**87,447,200**

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

No.1-4, IT Park, Behind KSSIDC Admin. Office, Rajajinagar Industrial Area, Rajajinagar, Bangalore - 560 044

	As at 31st March, 2013 (Rupees)	As at 31st March, 2012 (Rupees)
Schedule 11 : Administrative and other expenses		
Fixed Assets		
Computers	279,720	609,674
Furniture & Equipments	544,235	211,989
Communications		
Courier Charges	896,741	803,207
Data Card Expenses	1,092,906	1,179,073
Email/internet & Wireless	617	86,881
Internet Charges	366,928	325,549
Mobile Charges	849,804	936,963
Postage & Telegrams	1,540	5,150
Telephone Charges	186,871	209,226
Office Running Expenses		
Advertisement Expenses	16,527	13,500
AMC for Equipments & Others	558,181	740,813
Bank Charges	82,736	73,569
Books & Periodicals	1,030	2,887
Computer Running Expenses	387,695	251,477
Electricity/Water /Maintenance Charges	1,325,150	1,612,252
Insurance -Assets	95,560	96,109
Office Expenses	641,036	424,296
Office Repairs and Maintenance	941,562	115,097
Printing & Stationery	1,568,894	3,440,262
Rent-Office	5,739,963	7,452,922
Rent - Others	1,392,706	880,021
Security Service Charges	268,992	264,060
Software Expenses	1,150,668	475,493
Staff Welfare-Tea/coffee/meal	174,182	263,368
Project House Expenses	115,934	145,463
Brokerage Charges	58,000	-
Other Expenses		
Documentation & Research	-	60,000
Meeting Expenses	2,608,202	4,594,522
Interest Paid-Income Tax	1,782	86,467
Travel Expenses-Staff & Consultants		
Local Conveyance	105,239	151,012
Travel Expenses-International	7,695,655	3,886,388
Travel Expenses-National-Accommodation	3,184,288	2,358,009
Travel Expenses-National-Air tickets	6,086,827	5,115,050
Travel Expenses-National-Others	5,145,811	3,070,791
Travel Expenses-National-Perdiem	2,710,820	2,171,267
Travel Expenses-National-Train/Bus	1,514,012	1,282,300
Consultancy Expenses	190,621	549,443
Vehicle Repair & Maintenance		
Vehicle-Insurance	52,830	83,494
Vehicle-Repair & Maintenance	1,517,985	2,053,761
Professional Charges-Audit Fees		
Audit Fees-Other Services	41,015	99,822
Audit Fees-FY-2011-12	-	220,600
Audit Fees-FY-2012-13	259,738	-
Professional Charges		
Professional Fees	31,806	902,549
	49,884,810	**42,501,576**

KARNATAKA HEALTH PROMOTION TRUST BANGALORE INDIA

BANGALORE

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