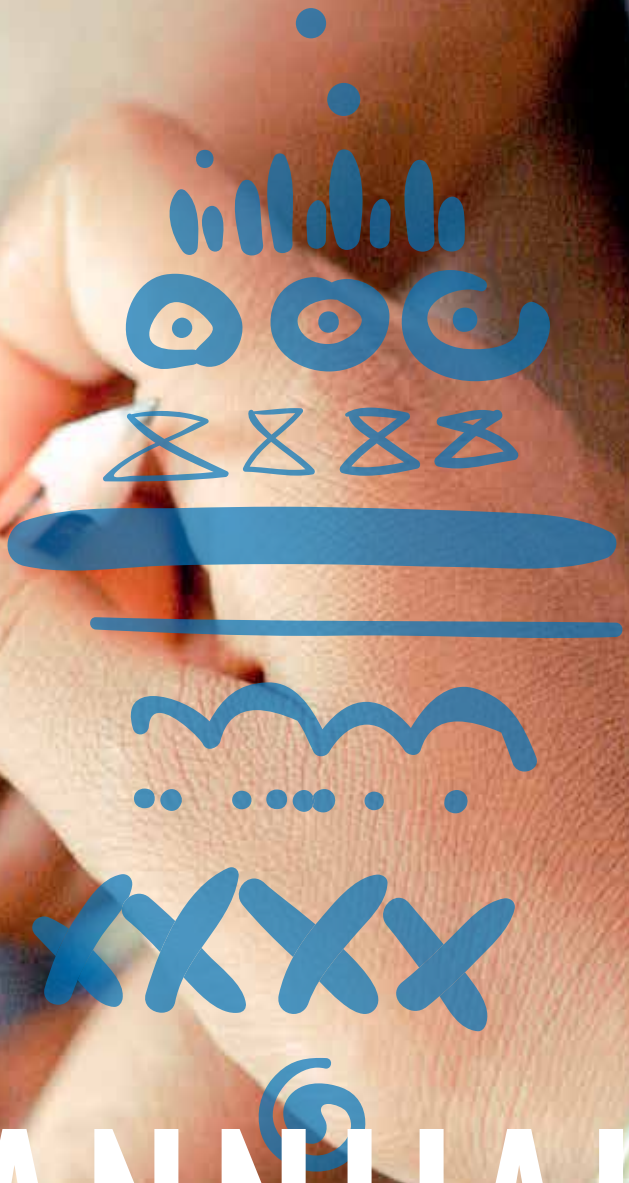
KHPT

KARNATAKA HEALTH PROMOTION TRUST



ANNUAL REPORT

2013-14

KHPT Annual Report 2013-14

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Annual Report 2013-14

KARNATAKA HEALTH PROMOTION TRUST

Message from the Managing Trustee

The year 2013 will be marked as a year of significance for Karnataka Health Promotion Trust. We have turned ten! It is with a mixed sense of pride and humility that we have grown in years and evolved in overall scope, approach and reach of our programmes.
These ten years have witnessed KHPT's evolution from primarily being a State lead partner for program implementation to a nationally recognised agency of excellence in programmes. KHPT has moved beyond its work on reducing proximate determinants of risk for HIV transmission, to undertaking programmes that attempt to understand and address the distal determinants that make populations vulnerable to the disease; from being focused on HIV prevention alone to expansion into a wider continuum of care, support and treatment.

The current programmes reflect a wider range of the communities we serve; populations that are most at risk to, affected by or living with HIV, women and children in rural and urban poor settings and a special focus on adolescents and children orphaned and vulnerable to HIV and other adverse conditions. Programmes now work beyond the sphere of HIV. KHPT also implements innovative programmes on Tuberculosis-diagnosis, treatment and adherence as a Private Provider Interface Agency and in Maternal, Neonatal and Child Health, in close coordination with the Government of Karnataka.

The underlying focus in each project is to develop innovations for optimum and sustained impact and to translate this knowledge at the national and global level through direct and indirect technical assistance. In this regard, KHPT's South to North (S2N) support to Rajasthan for scale up of its targeted interventions for HIV prevention and support to Uttar Pradesh to map health facilities for maternal, neonatal and child health are commendable. Numerous countries from Asia and Africa visited Karnataka to learn HIV prevention, and KHPT provided technical support to countries to develop their HIV policies. KHPT has also been a learning ground for a number of students pursuing careers in Public Health, Community Medicine and Social sciences.

As an organization, we pursue our social responsibility towards Orphan and Vulnerable Children, both through funded programmes and through staff contributions in time, materials and finances. As we continue to strive to 'make a difference' in the lives of marginalised communities, we count on the commitment and passion of every KHPT team member, the sustained support of our donors and our partnerships with Government, academia and non-government organisations.

"Engage, Enable, empower…"

Dr. Reynold Washington
Managing Trustee

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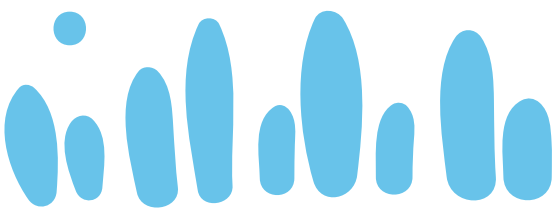


Acronyms & Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
AMSTL	Active Management of Third Stage Labour
AWW	Angan Wadi Workers
ASHAs	Accredited Social Health Activists
ART	Anti-Retroviral Therapy
AAY	Antodaya Anna Yojana
AMICALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
BMGF	Bill and Melinda Gates Foundation
BATS	Bureau of AIDS, TB and STI
CLHIV	Children Living with HIV
CFAR	Centre for Advocacy and Research
CBO	Community Based Organizations
CST	Care Support & Treatment
CBTS	Community Behaviour Tracking System
CoC	Continuum of Care
DAPCU	District AIDS Prevention and Control Unit
DWCD	Department of Women and Child Development
DAC	District AIDS Control
DC	District Counsellor
DCPU	District Child Protective Unit
DOTS	Directly Observed Therapy Short course
DHO	Distruct Health Officer
DFID	Department of International Development
DV	Domestic Violence
FSW	Female Sex Worker
FLW	Frontline Worker
FHI	Family Health International

GOI	Government of India
GoK	Government of Karnataka
GSPP	Gender Sensitization and People Friendly Police Project
GBV	Gender Based Violence
GF	Global Fund
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GI-CASH	Gender Integration and Committee against Sexual Harassment

HB-FFC	Home based Family Focused Communication?
HBMNC	Home based Maternal and New born Care
HMIS	Health Management Information System
HIV	Human Immuno-deficiency Virus
HRG	High Risk Group

IHAT	India Health Action Trust
IPV	Intimate Partner Violence
IDU	Injecting Drug USER
ICASA	International Conference on AIDS & STI in Africa
ICAAP	International Conference on AIDS in Asia Pacific
ICTC	Integrated Counselling and Testing Services
ICPS	Integrated Child Protection Scheme
IMR	Infant Mortality Rate
ILN	India Learning Network
ICMR	Indian Council of Tropical Medicine

JHA	

KHPT	Karnataka Health Promotion Trust
KJA	Karnataka Judicial Academy
KSAPS	Karnataka State AIDS Prevention Society
KP	Key Population

LSHTM	London School of Health & Tropical Medicine
LFU	Lost to Follow up

MNCH	Maternal Neo Natal Child Health
MO	Medical Officer
MoH	Ministry of Health
MSM	Men having Sex with Men
MSM-T	Men having Sex with Men-Transgender
MIS	Management Information System
MDR TB	Multi Drug Resistant Tuberculosis
MARP	Most at Risk Population
M & E	Monitoring & Evaluation
MCTS	Mother- Child Tracking System

NRHM	National Rural Health Mission
NGO	Non-Governmental Organization
NPIP	Non Paying Intimate Partners
NLSIU	National Law School of India University
NIMHANS	National Institute of Mental Health and Neuro Sciences
NHSRC	National Health System Research Centre
NASCOP	National AIDS and STD Control Programme
NACA	National Agency for control of AIDS

ORW	Outreach worker
OI	Opportunistic Infection
OVC	Orphan AND Vulnerable Children
ODV	On- site Data Validation

PR	Primary Recipient
PO	Program Officer
PLHIV	People Living with HIV
PHC	Public Health
pHCP	Private Health Care Provider
PPIA	Public Private Interface Agencies

RMNCH+A	Reproductive Maternal Neo natal Child Health + Adolescents
RNTCP	Revised National TB Control Program
RPC	Research Programme Consortium

SHOPS	Strengthening Health Outcomes through the Private Sector
SJMC	St. John's Medical College
SCMT	Supportive Community Monitoring System
SVYM	Swami Vivekananda Youth Movement
STI	Sexually Transmitted Infections
SBA	Skilled Birth Attendant
SR	Sub Recipient
SSR	Sub sub recipient
SDMC	School Development Management Committee
SFH	Society for Health
TI	Targeted Intervention
TACAIDS	Tanzania Committee on AIDS
TWG	Technical Working Group
TOT	Training of the Trainer
UNDP	United Nations Development Programme
UNTF	United Nations Trust Fund
UNFPA	United Nations Framework for Population Activities
UAC	Uganda AIDS Commission
UoM	University of Manitoba
USAIDS	United States Aid for International Development
VHC	Village Health Committee
VHSC	Village health and Sanitation Committee
WCD	Women and Child Development
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZNSP	Zanzibar National HIV Strategic Plan

Overview of KHPT

About KHPT

Karnataka Health Promotion Trust (KHPT) is a Trust registered in the year 2003, under the provisions of the Indian Trusts Act, 1882. KHPT works closely with the University of Manitoba, Canada and the Karnataka State AIDS Prevention Society to empower communities in Karnataka and India to improve their health, reduce the incidence and burden of HIV and AIDS and assert their rights and dignity.

With time, KHPT has broadened its scope of work to ensure a complete continuum of care and prevention which includes diagnosis, treatment, psychological counselling and social support for high-risk groups, vulnerable populations.

Vision

"Empowered communities, in Karnataka and India, working collectively to improve their health and assert their rights and dignity."

Mission

- Enhance the health and well-being of communities through the delivery of innovative, evidence based, result oriented, gender transformative, comprehensive, sustainable and scalable programs and services, in partnership with communities served.
- Strengthen the capacity of organizations including community based, governmental, non-governmental organizations, to plan, deliver, monitor and evaluate programs that enhance health and well-being of the communities.
- Develop as a learning organization continually translating knowledge and approaches through reflection, research and engagement with our peers, in India and globally.

Project Briefs

Sukshema project (2009-2015) is the Maternal & Child Health Program, implemented by KHPT in partnership with the National Rural Health Mission Program of the Government of Karnataka. It is funded by the Bill & Melinda Gates Foundation and supports the state of Karnataka and India to improve maternal, new born and child health outcomes by improving availability, accessibility, utilization and coverage of critical MNCH interventions for rural populations of eight priority districts in northern Karnataka.

STRIVE (2011 to 2017) is a research consortium, investigating the social norms and inequalities that drive HIV. A collaboration between six partners, STRIVE is funded by the UKaid/ Department for the International Development and led by the London School of Hygiene and Tropical Medicine (LSHTM). KHPT as part of STRIVE is implementing and evaluating two programmes- Samata and Samvedana Plus, focusing on how structural factors, such as gender inequality and violence drive the HIV epidemic.

India Learning Network (ILN) (Jan 2012-March 2015) is implemented in partnership Family Health International (FHI) 360 and the University of Manitoba. It is funded by the Bill & Melinda Gates Foundation. The project aims to influence global HIV prevention practices by widely disseminating the approaches and learning that evolved from scaled HIV interventions in India. The project works to enhance the capacities of the programmers, policy makers and implementers from countries in Asia and Africa.

Samvedana (2012-2015) is funded by the United Nations Trust Fund and implemented in partnership with sixteen community based organizations (CBOs). The project is implemented in collaboration with the National Law School of India University, Karnataka State AIDS Prevention Society, Karnataka Judicial Academy, Centre for Advocacy and Research and the National Institute of Mental Health and Neuro Sciences. The project works towards addressing violence against women in sex work in 30 districts of Karnataka.

Strengthening Health Outcomes through the Private Sector Tuberculosis Prevention and Care (SHOPS TB) (2014-2015) is a comprehensive Private Provider interface Agency that is (PPIA) that is funded by the USAID and implemented in partnership with Abt Associates.

The primary components of this project include capacity building of the private practitioners , communication activities to engage with the urban poor and supportive services to enhance adoption of Standards for TB care in India (STCI). The initiative covers 42 towns in 12 districts of Karnataka.

Vihaan (2013-2016) is a HIV care and support initiative, funded by the Global Fund. KHPT is sub-recipient to India HIV AIDS Alliance (primary recipient). The project aims to enhance survival and quality of life of people living HIV in across 30 districts in Karnataka.

Place Aids Fund Project (2013-2015) is funded by the MAC AIDS Fund. The project is implemented in partnership with Sneha Charitable Trust and INSA, India and has networked 16 institutions. The project aims to create platforms of learning alongside children for an effective (PLACE) AIDS response and to enhance the quality of life of children living with and affected by HIV in both institutional and community settings.

South to North (January 2013 to March 2014) is funded by the Bill and Melinda Gates Foundation. The project aims to provide technical support to the government of Rajasthan to scale up the coverage and improve the quality of targeted interventions in the State.

Key Projects

2.1. Sukshema Project

Sukshema project supports Karnataka and India to improve maternal, new born and child health outcomes by improving availability, accessibility, quality, utilization and coverage of critical MNCH interventions for the rural populations through development and adoption of effective operational and health system approaches. The project covers eight priority districts in northern Karnataka viz. Bagalkot, Bellary, Bijapur, Gulbarga, Koppal, Raichur and Yadgir.

Funded by:
Bill & Melinda Gates Foundation

Project duration:
April 2013 to September 2015

Implementation Partners:
University of Manitoba,
St. John's National Academy of Health Sciences, Karuna Trust, Intra Health, Government of Karnataka

Highlights of Activities and Accomplishments

A. Facility based interventions (Mentoring Interventions) - Activities and Impact

1. Improving quality of care at birth and immediate postpartum care at facilities (facility-based interventions)

The use of team-based quality improvement processes combined with ongoing mentoring support has generated improvements in the quality of care at PHCs. The following section enlists some of the notable improvements:

- **Increased availability of drugs and supplies -** Mentors and PHC teams have stated that mentoring intervention has brought about an increase in the availability of essential medicines and drugs at most of the pilot PHCs which were observed to have very scarce availability of the same during the initial days of the intervention. Mentoring has made Medical officers much more

supportive and pro active in making arrangements to acquire essential drugs at the facility, by utilizing the untied funds. PHCs have acquired the necessary infrastructure like- autoclaves for delivery and other equipments to deliver essential health services.

- **Improved organization of labor room** - Mentors have observed significant improvements in the organization of the labour room in terms of its equipment, and increased cleanliness. Many PHCs now have kits readily available for emergencies. Many have guidelines on the walls and a list of essential drugs.

- **Decreased labor augmentation -** Mentors have reported that although some senior nurses are reluctant to change their practices but a significant number of nurses have stopped performing labor augmentation.

- **Improved adherence to SBA guidelines for normal deliveries** - The intervention has enabled mentors to assist and observe normal delivery cases. This has helped mentors to understand and assess how well nurses are able to handle normal deliveries and complications that arise. Mentors have reported an improvement in the rate of adherence to the SBA guidelines, use of the partograph, practice of AMTSL and overall clinical care given by nurses.

- **Increased capacity and confidence to manage maternal and newborn complications** - Nurses have reported that they are now more comfortable and confident in handling maternal complications with the help of mentoring and use of case sheets.

- I**mproved referral processes** - Mentors and PHC teams have reported that their referral processes are far more systematic since the mentoring programme started. PHCs are now more likely to have referral directories to arrange referral facilities in advance.

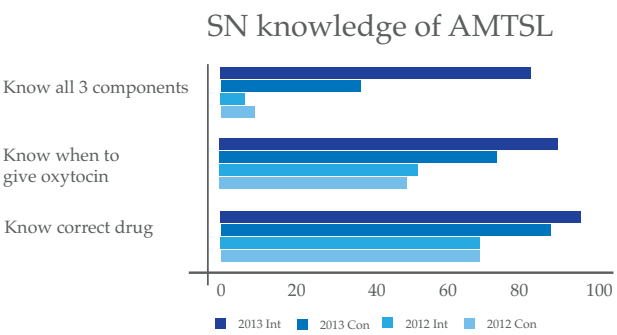
2. Acceptance of Case Sheets

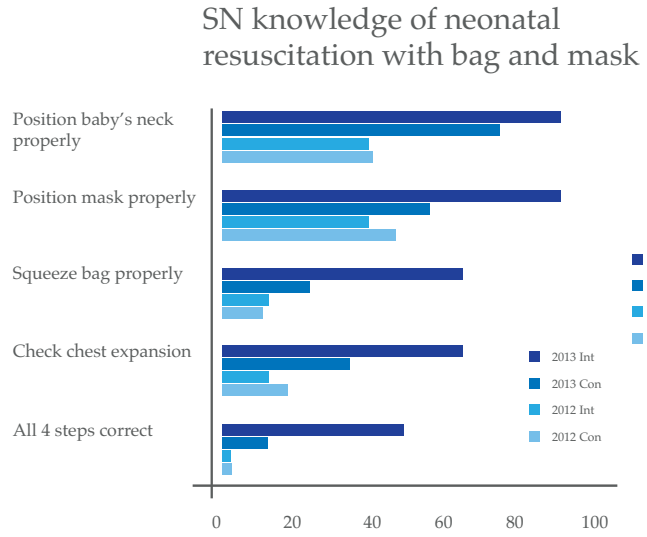
Analysis of case sheets indicates its acceptance by the providers as a job aid in imparting quality care to the clients. The case sheet summaries indicate improved management of maternal and newborn complications through early diagnosis and pre-referral management. The mentors have been able to sustain the improvements over visits in terms of use of case sheets for providing evidence based care, prompt detection and management of complications and in ensuring availability of critical drugs and supplies.

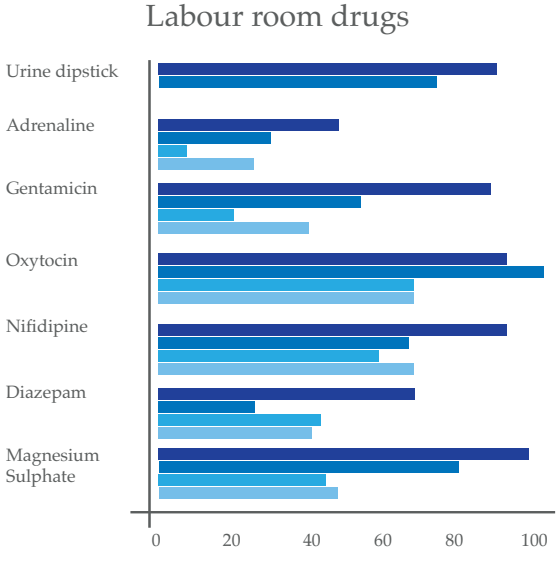
3. Completion of End line Evaluation

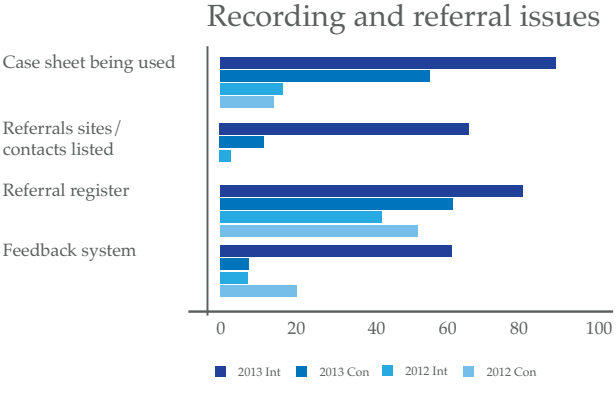
The end line evaluation of the onsite mentoring programme was completed in the month of September 2013. Soon after that, the interventions were scaled up to the control PHCs in the pilot districts, thus enabling 100 % coverage of 24/7 PHCs.

The end line evaluation findings have reported that the PHCs that received mentoring significantly performed better than those that did not. The knowledge related to active management of third stage labor and management of complications as well as skills in demonstrating the use of bags and mask for new-born has remarkably improved among nurses. The intervention PHCs have reported better availability of critical drugs such as magnesium sulphate, nifedipine and gentamycin. Earlier these drugs were not indented probably because there were not used; they have started indenting these drugs. Further, untied funds are increasingly being used to procure and stock up drugs. The referral system has also remarkably improved in the intervention PHCs, in terms of maintaining a referral directory, documenting and following up of referrals.









4. Scaling up and Managing Mentoring Programme

After completion of the end-line survey for on-site mentoring, the project has recruited and trained additional nurse mentors for the control PHCs in two pilot districts. The project now has 55 trained nurse mentors.

5. Impact of Advocacy Initiatives of the Project

The project has intensified its advocacy efforts with the district officials to garner greater support and has also increased the coordination efforts with the community intervention to influence community behaviours and local support. Since January 2014, the mentoring strategy has been re-designed to provide greater focus on the high volume PHCs, in order to maximize the outcomes. Mentors visit the high volume PHCs every month which give them an opportunity to demonstrate actual practices and support the providers to imbibe the same.

6. Capacity Building of Nurse mentors

The project has continued to build capacities of nurse mentors through refresher trainings with the help of the clinical consultants from St John's as well as an international consultant, Dr Swaraj Bhandari. Several rounds of clinical postings were given to offer an exposure. Apart from this, the regular handholding visits are conducted throughout the year, by the consultants from St Johns and KHPT/UoM.

Image 1. Capacity building trainings for nurse mentors

7. Development of training manuals

Experiences from the field have been penned down, alongside several training manuals for nurse mentors have been drafted. The process document has been completed, both for the pilot and scale up districts and is available (as both short and detailed reports). A short video has also been developed related to mentoring program.

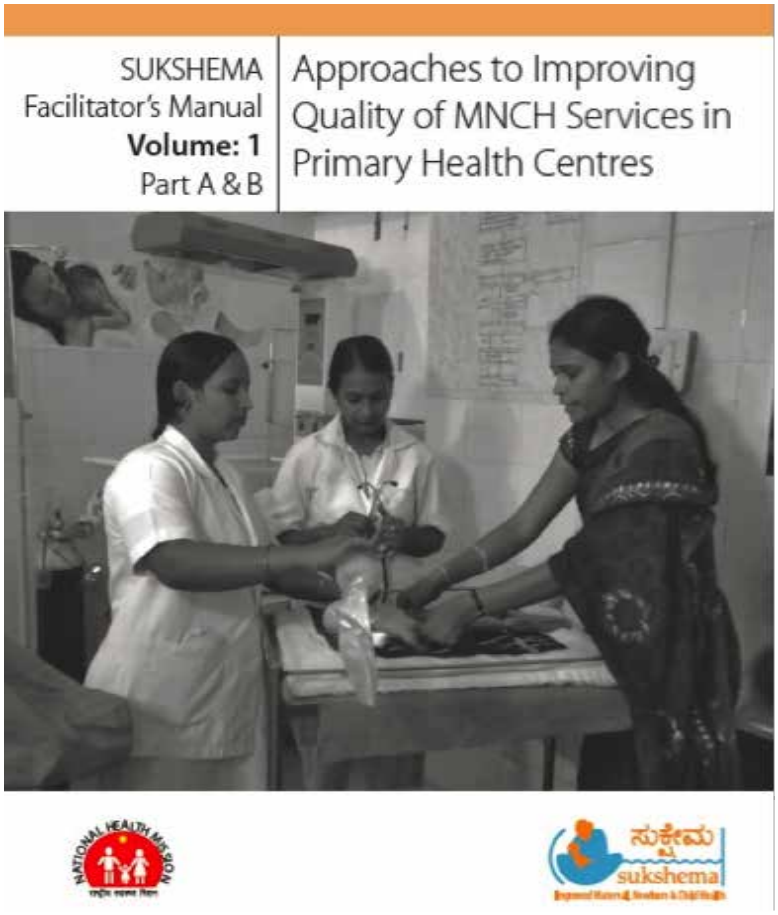


Image 2. Training Manuals developed on Approaches to improve quality of MNCH services in Primary Health Centres.I

B. Community Interventions - Activities and Impact

Sukshema project's community interventions are designed to work on community-level issues through building the capacity of accredited social health activists (ASHAs), Anganwadi workers (AWWs) and junior health assistants (JHAs) work to improve birth preparedness and maternal and new-born practices at the community level.

The community intervention and mentoring programme have coordinated together in each district to see how they complement each other in ensuring MNCH care continuum across levels of care.

I. Formation of Arogya Mantapa:

The Arogya Mantap (AM) has been designed as a forum to promote collaborative action at the sub centre level among all the front line health workers such as the ASHA workers, Anganwadi workers, JHA as well as community representatives from the VHSNCs. Arogya Mantapa has evolved as one of the community interventions under project Sukshema, with the main objective of strengthening the base set by interventions like the FFC which emphasizes on the importance of collaboration, mutual support and shared goals among the front line health workers in order to foster a positive work environment for the functionaries. AM also aims to create the space for building stronger team relationships by understanding each other's struggles, and respecting each other's rights.

Image no. 3. Inauguration of the Arogya Mantapa.

Image no. 4. Arogya Mantapa -Sub centre level forums.

Impact of Community Intervention

Arogya Mantapa- a means to check child marriages

Every year the temple trustees of P. K. Hally village organize mass marriages during the month of Shravana, when child marriages are commonly seen. The AWW and ASHA workers discussed this grave concern in their Arogya Mantapa meeting and tried to evolve ways to prevent it. They jointly took a decision to convene a meeting at the Gram Panchayat with all the GP and TP members FLWs, VHSNC members and trustees to discuss the issue. As a result of this meeting, the GP members decided to entrust the Trustees with the responsibility of meeting with the suspected family members (identified by AWWs and ASHAs) and scrutinize the age details of the brides and submit this information to the GP. The trustees checked this with the 30 couples enrolled for the mass marriage. After intensive scrutiny, 4 couples were removed from list. In addition to this, a jatha was planned to inform and educate children and their families about the importance of age at marriage and address their vulnerability to child marriages.

II. Monitoring data for both pilot and scale up districts

The monitoring data for the project is derived from two sources i.e. Enumeration Tracking Tool/ Community Demand List summaries as well as periodic Community Behaviour Tracking Surveys.

a. Enumeration Tracking Tool summary: The ETT is used by the ASHAs to collect information on critical services like delivery, Post Natal Care, ANC, vaccination. This information is then analysed by the project at the district, sub-district, PHC and sub centre level. The progress is measured against the target the ASHA had fixed at the end of the previous reporting month. In the pilot districts, close to 70% of the ASHAs who were trained by the project are now reporting with the of use ETT summaries. The gap in reporting is largely related to capacities of the ASHAs; close to 20% ASHAs are illiterate and need intense handholding.

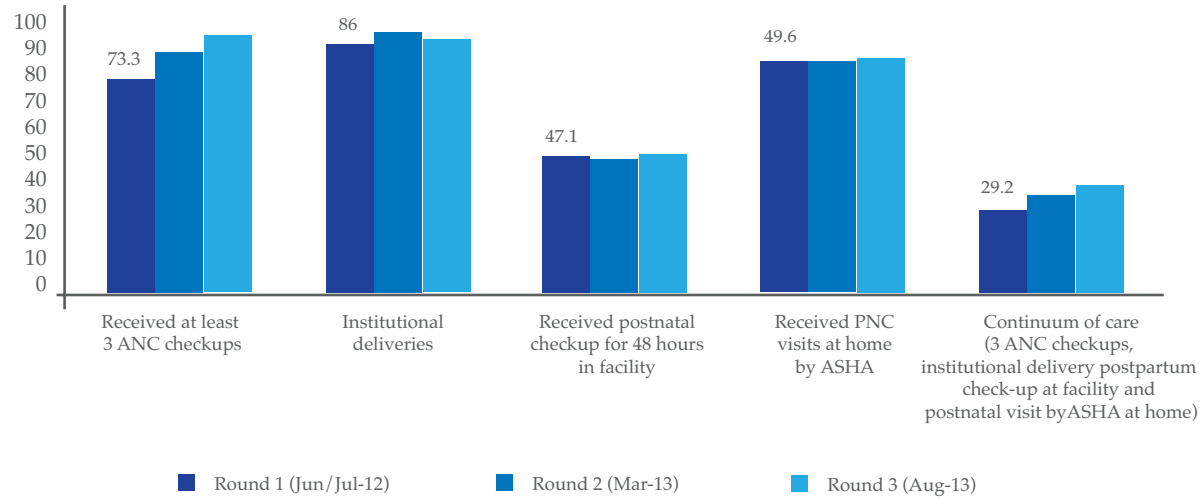
b. The community behaviour tracking survey is a concurrent mobile phone (GPRS enabled) based monitoring Survey which is used by the project to monitor its progress towards achieving outcomes, especially with regards to the community level interventions. The CBTS is repeated every four months for a project district and thus helps us to understand the impact of our interventions.

CBTS indicators steer programme direction: **An explanatory study**

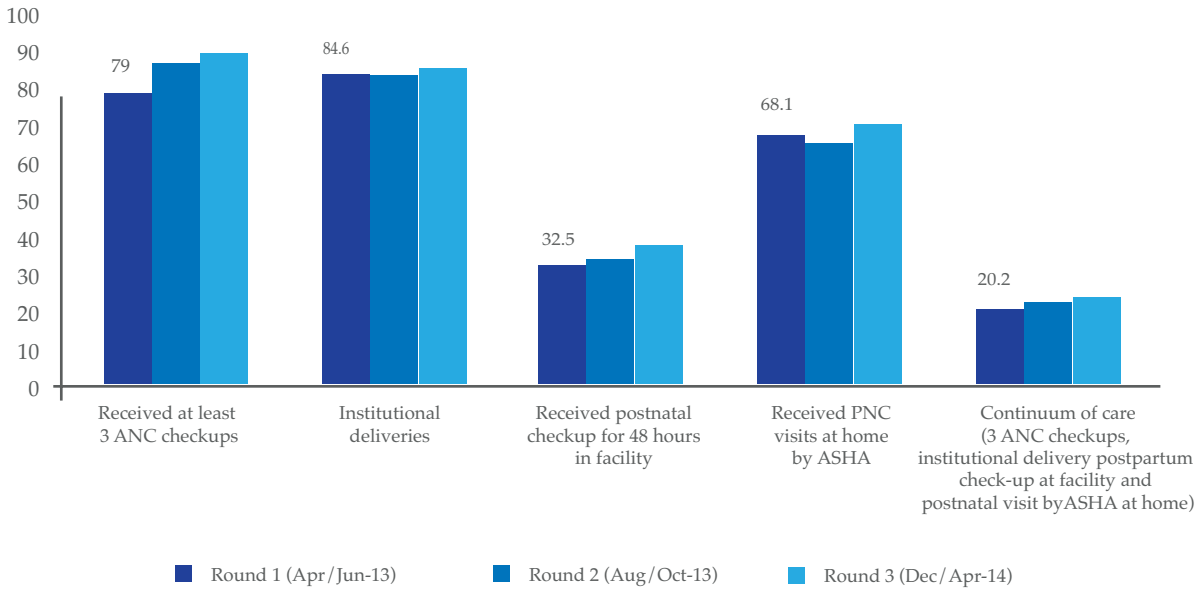
The Bellary district team, in order to review the progress in the district decided to look at the district's performance on priority indicators of the CBTS. They evolved a simple mechanism to do this. Every taluk team comprising of the nurse mentor and community coordinator chose one CBTS indicator to track the taluk's progress. For example, 48 hrs stay in the facility after delivery, breast feeding within hour and birth planning. The team had consultations at the facility level, interactions with the FLWs and community representatives to assess the taluk's current performance on the indicator and accordingly evolve an action plan together. This process helped them understand the critical need on the field to hold such joint consultative meetings between both community representatives and facility staff at regular intervals. The taluk teams developed strategies to ensure that the taluk's performance on the chosen indicator would improve. This approach proved to be a success after it was first piloted in one PHC and subsequently has been scaled up to others. The district team has learnt to conduct frequent joint consultations on CBTS indicators to do a holistic assessment of the taluk/ district and direct the program and the implementation processes well.

III. A progressive trend in ANC check-up rates

The concept of ANC registration has been redefined, only when a woman receives a Thayi Card, that woman should be called as being registered for ANC. ANC check-up rates have always been high, but has substantially increased further in the project period in all districts. Proportion of women who stayed for 48 hours after delivery and proportion of women who received all services across continuum are gradually improving.



Changes in selected maternal care indicators: Bagalkot & Koppal



Changes in selected maternal care indicators: Bellary, Gulbarga, Bidar, Bijapur, Raichur & Yadgir

IV. Development of Training Tool Kit

The project has developed a training tool kit based on the experience of training FLWs in the management of outreach in the field. External consultants have also documented the strategies adopted in implementation of community interventions in a systematic manner both in the pilot and scale up districts. The training kits and process document are useful for replicating similar interventions.

V. Finalization of the software for ASHA Tablet

After the finalization and launch of ASHA diary, another development related to the community intervention has been the finalization of the ASHA tablet using an android based application; the tab incorporates the Enumeration and Tracking Tool (ETT) (or) Community Demand List (CDL) as well as the Family Focused Communication (FFC) related audio/ video messages. It helps ASHA to document her visits and contacts. Currently, the software is finalized, the ASHAs are trained and the intervention is rolled out. The learnings about the use of these tabs will help the state government to roll out a mobile phone application for ASHAs.

C. Additional Monitoring & Evaluation Activities

Additional Monitoring Activities: HMIS & MCTS

Sukshema's Monitoring and Evaluation process is built around the quality improvement interventions of the project. The monitoring activities undertaken for each of the project interventions have been illustrated in the previous section. Thus, the following is to briefly explain about other M&E activities undertaken by the project.

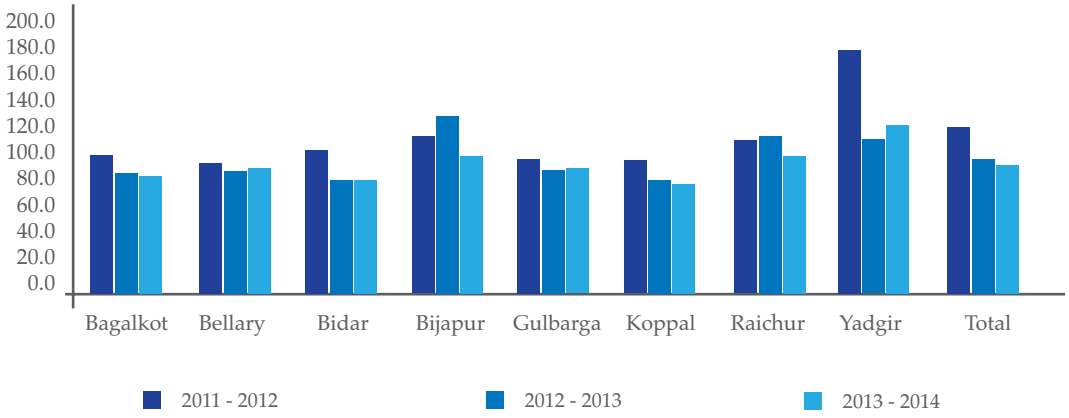
- The project monitoring team has extended its support to the Department of Health and Family Welfare, National Rural Health Mission, at the state and districts(under the project coverage), for strengthening the use of Health Management Information System (HMIS) and Mother and Child Tracking System (MCTS).

- The M&E specialists from KHPT have extended support to the NRHM to organize a five day induction training workshop for the 14 newly recruited M&E Managers of the state NRHM. The KHPT specialists have held sessions on the practical use and analysis of HMIS and MCTS data.

- The project staff have completed another round of training for the Junior Health Assistants (JHAs) with special emphasis on MCTS. Around 2600 JHAs, 450 Data Entry Operators (Pharmacists, Staff Nurses etc.), around 250 Medical Officers, and 300 Lady Health Visitors have been trained till date. Sukshema M&E specialists and in some cases M&E Managers from NRHM have been the resource persons for the trainings organised by the Block Programme Managers with official order of the District Health Officers(DHO). These trainings have been organised at level of PHC clusters, block level, or on account of priority facilities (high delivery load) as per the districts' convenience. The topics covered in the training include:
    - methods of sending SMS
    - codes to be followed
    - process of reducing data entry lag
    - update services in MCTS
    - use of work-plan
    - HMIS data validations
    - clarification regarding indicator definitions

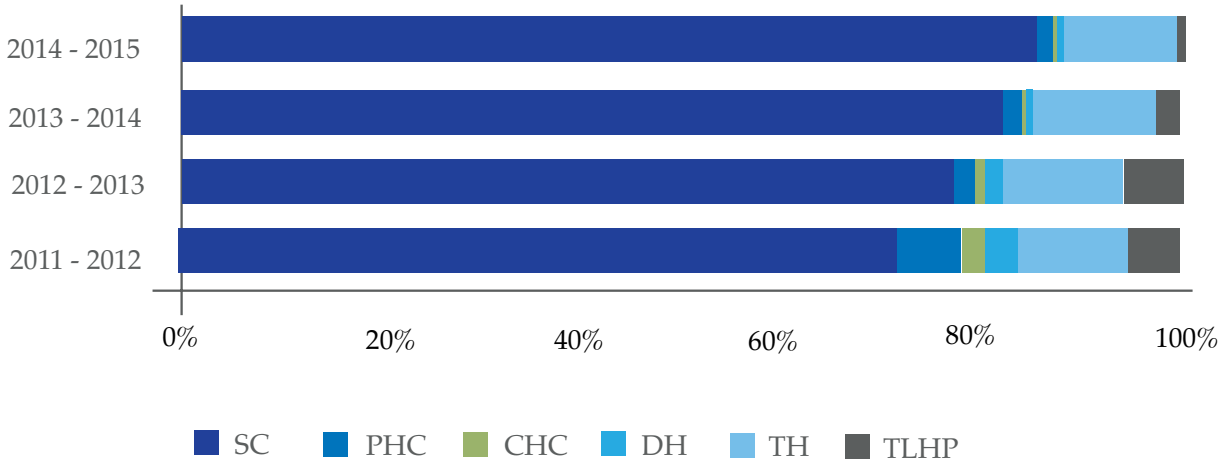
Challenges in HMIS & MCTS:

HMIS measures several programmatic indicators but being an aggregate level of data, it suffers from the lack of a denominator to provide accurate estimates for various indicators. Duplication of reporting may occur, for instance, if services are provided at the sub-centre area but gets reported also by PHCs or vice-versa, it leads to huge miscalculation of estimates. MCTS provides individual level data, but, suffers from incompleteness. This is caused by reasons like, JHAs not being able to/not send/ing messages, delayed Annexure I entry at the facility, subsequently SMS sent by JHAs may not be accepted by the server, women not carrying Thayi Card to the place of delivery leading to non-entry of Annexure II, etc. However, over the period, quality of HMIS and MCTS has improved, and following are some illustrations of the same:



% ANC registration against estimated pregnancies

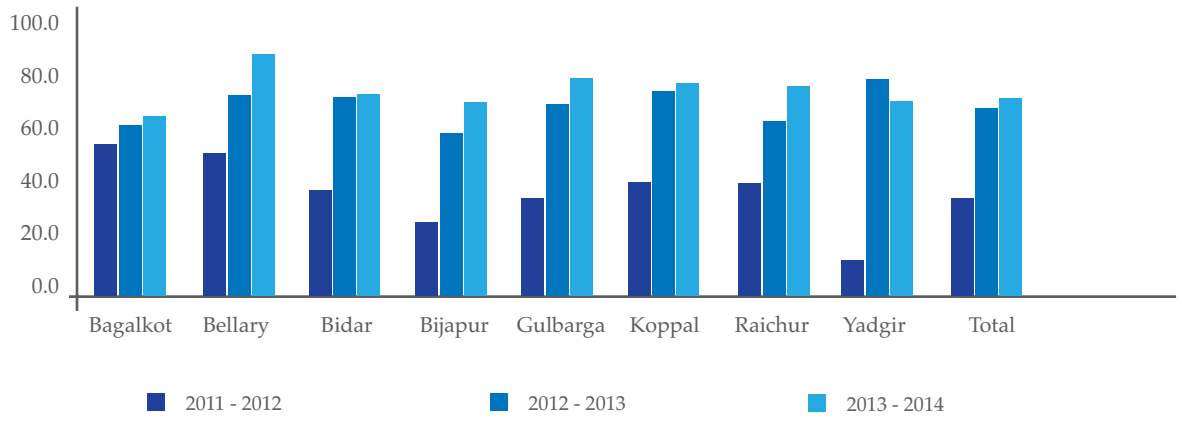
The chart below shows how proportion of registrations shifted towards Sub-Centres, more from PHCs, reducing chances of duplication.



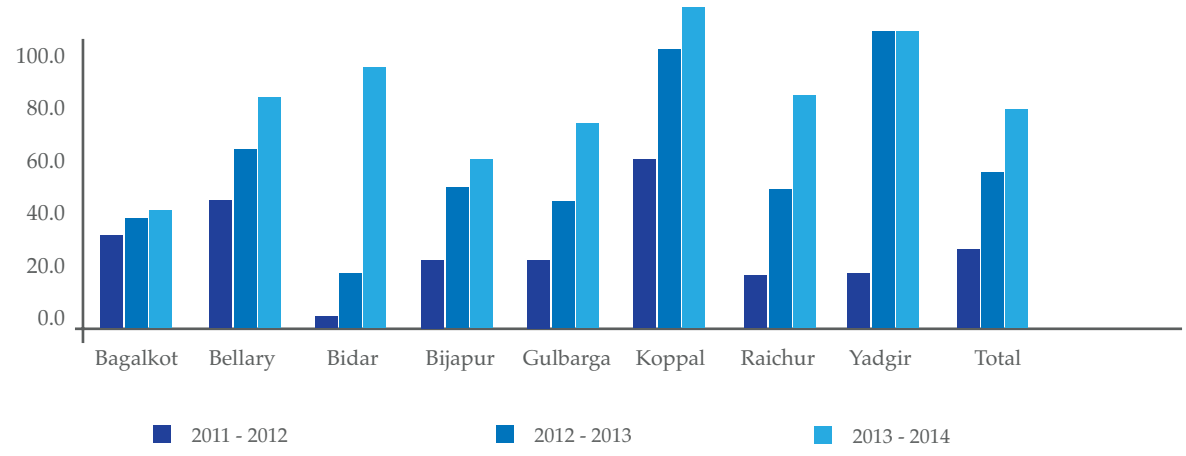
Distribution of ANC registration among Health Facility Types

The following charts reflect the improvement in MCTS status in comparison to HMIS. All ANC Registrations reported in HMIS should also be reflected in MCTS. In MCTS, Annexure I is for ANC registration. Similarly, all the deliveries reported by a facility in HMIS need to be available in MCTS as well. Annexure II in MCTS is for recording of deliveries.

The charts below show improved use of MCTS. However, despite our efforts, HMIS and MCTS suffer from system level issues like, supply of Thayi cards, frequent strikes by providers, lack of internet connectivity and non-availability of any dedicated Data Entry Operators.



MCTS Annexure-I status against HMIS ANC registration



MCTS Annexure-II status against deliveries reported in HMIS

2.1.2. Uptake of Project Intervention at the State and National Level

1. Project Sukshema has successfully advocated for an additional position of district M&E manager for all the districts to support HMIS/MCTS activities. Subsequently, the project has supported the recruitment and training of the M&E managers for 14 districts in the first round. Project also supported NRHM in designing a survey for capturing infant mortality rate.

2. During the year, the ASHA diary has been revised based on the feedback by the officials from National Health Systems Resource Centre (NHSRC) and State government. Subsequently, the ASHA diary has been finalized and launched in the six scale up districts. Simultaneously, the project has employed a different strategy for scaling up the community intervention activities.

Image no. 5. Launch of ASHA diary by Dr Suresh Mohammed, Mission Director, NRHM and other state officials during January 2014. (Beyond Project +)

3. Support to UP MNCH TSU: A mandate of the Karnataka project was to inform and support other Foundation projects in the country, specifically the UP MNCH TSU project. The senior Sukshema management team, Mr. H L Mohan and Dr. Krishnamurthy J have provided regular mentorship to the community and facility interventions teams of the UP MNCH TSU, respectively. In addition to contributing to the broad design and planning of the UP TSU project, they have specifically supported in recruitment of team leaders and technical specialists, development of induction training program including exposure visit to Karnataka MNCH programs and development of detailed work plans including recruitment and training plans, etc.

4. Knowledge transfer to other regions: The UP NRHM plans to adopt certain key interventions piloted in Karnataka. Other states of Rajasthan and Andhra Pradesh have reviewed the tools and methods of community and facility interventions and have decided to adopt up certain aspects of them. The case sheets were also shared with the UNICEF team that showed lot of interest in the work of Karnataka. UNICEF has contracted Catholic Association of India (CHAI) to implement a nurse mentoring program in the state; CHAI is in touch with the project and we have shared all the tools and documents pertaining to the mentoring interventions. The 'Better Birth' project in UP that is conducting a RCT of the 'safe birth checklist' had a teleconference meeting with project Sukshema to understand the nurse mentoring program as they intend to introduce mentoring in one of the arms of the trial. Thus, the experiences from the Karnataka project have been successfully translated into different contexts.

2.2. Strive - Tackling structural drivers of HIV Epidemic, Research Programme Consortium

As an initiative to fulfil the core intent of Strive, KHPT has launched two projects under STRIVE, namely, Samata & Samvedana Plus. These two projects are independent and STRIVE is evaluating both the interventions

Funded by:
Department for International Development through London School of Hygiene and Tropical Medicine

Project Duration:
2011-2017

Samata is a project in collaboration between Karnataka Health Promotion Trust (KHPT) and the London School of Hygiene and Tropical Medicine (LSHTM); it is both a research study and a programme to support girls from scheduled caste and schedule tribe (SC/ST) communities to delay marriage and entry into sex work by continuing in high school. KHPT, in partnership with the Government of Karnataka, is implementing Samata to reach 3600 SC/ST girls in 69 high schools in 119 villages in Bagalkot and Bijapur Districts in northern Karnataka. Government schemes to encourage girls' education will reduce the burden of school expenses on poor families. Samata is a pioneer in focusing on gender norms as it seeks to build positive norms to increase the value that communities place on girls themselves and on their education.

Key achievements

- The Government of Karnataka has chosen Samata as one of the five best practices in girls' education in the state. A team constituted by the government has documented the impact of Project intervention by Samata in Bagalkot. The document reflects the success and impact of the programme on the community.
- The Commissioner of Education has issued a circular authorized by the Government addressed to the Deputy Directors of Public Instruction to depute teachers in the project districts for Teacher Training Programmes conducted under Samata.

- Engagement with the Department of Education at the state level resulted in the government selecting Samata to be supported with the innovation grants. The programme has received Rs.25, 00,000 under this grant.

- Parinita Bhattacharjee, Co-Project Director of STRIVE in KHPT attended a three day symposium, in June-July 2014, to help Malawi government develop their HIV prevention strategy.

- The International Day of the Girl Child celebrations by KHPT was reported by Girl Rising and a postcard was produced on the same and featured in the Girl Rising website.

field diaries

Linking 'Will' to a 'way' forward

Durgavva stays with her mother at Sorgav village and studies in the ninth standard at a school in their village. She lost her father 3 years back. Durgavva's aunt is a brothel madam and has been persistently trying to persuade Durgavva's mother to put an end to her studies and let her start earning by entering into to sex work at the brothel run by her. Durgavva's mother held on to her decision firmly and never gave into the suggestion by her sister. She was rather worried and thinking of ways to ensure that Durgavva remains far from any such thing and only focuses on education.

For all good reasons Durgavva's mother came across Mahadevi, an outreach worker and explained to her the entire situation, she also requested her to suggest ways to ensure Durgavva's education. The mother also insisted that Durgavva should be ideally sent to a hostel to pursue further education so that she is away from all distractions and is able to concentrate on her studes.

ORW has linked her to Bhandavya residential school at Kustagi where education and hostel facility are free. This linkage has been done through Anthyodaya NGO. Durgvva's admission is done. Four other girls from Mudhol taluk have joined the school.

- The Samata brochure was featured in the Adolescent Girls dispatch by the Coalition for Adolescent Girls.
- In June 2013, Parinita Bhattacharjee participated in a WHO meeting, held in Geneva, on 'Consultation on the development of a Technical Guide for countries to set targets for HIV prevention, treatment and care for sex workers, men who have sex with men and transgender people.'
- Parinita Bhattacharjee presented on structural drivers at the International Conference on AIDS and STIs in Africa (ICASA) 2013.

2.2.b. Samvedana Plus

Samvedana Plus is a three-year programme (2013-2016) funded by Bill and Melinda Gates Foundation and United Nations Trust Fund that integrates research and interventions to understand and address structural factors that increase HIV risk and vulnerability of female sex workers in intimate partnerships. The programme aims to examine and find ways to modify factors that contribute to intimate partner violence (IPV) and impede condom use in such relationships.Karnataka Health Promotion Trust (KHPT) is implementing Samvedana Plus in northern Karnataka, India, in partnership with community-based organizations (CBOs) of sex workers like Chaitanya AIDS Tadegattwa Mahila Sangha and AIDS Jagruti Mahila Sangha. Within the DFID-funded STRIVE research consortium, KHPT and the London School of Hygiene and Tropical Medicine (LSHTM) are evaluating the impact of Samvedana Plus on violence and condom use in sex-workers' intimate relationships. The programme covers 2286 FSWs and their intimate partners living in 91 villages and seven towns of Bagalkot and Bijapur districts in northern Karnataka, India.

Accomplishments

- Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, Volume 16, Issue 2, 2014 published one peer-reviewed article 'Circumstances, experiences and processes surrounding women's entry into sex work in India.' in PubMed Information.
- A Community Advisory Board has been set up for the Samvedana Plus evaluation. Community Researchers (female sex workers) have been trained to conduct qualitative research.
- The study exploring the impact of norms around masculinity, gender and violence on the dynamics of intimate partner violence among the female sex workers (FSWs) was completed. The report, 'Understanding the masculinities, gender norms and intimate partner violence affecting the female sex workers of northern Karnataka: A qualitative inquiry with intimate partners.' discussed the study findings and was published by KHPT in March 2014.

Key Activities

i. Regular workshops are held by the project team to counsel individuals (women in sex work) and couples among sex workers to build their skills to change norms and improve communication in relationships, inform them about protective laws and empower sex workers to identify solutions and support mechanisms and to take action against abuse and violence in intimate relationships.

ii. Capacity building of CBOs working for sex workers to prioritise and address intimate partner violence, encourage members' critical thinking on partner violence and strengthen the crisis management systems in CBOs to support sex workers experiencing partner violence.

iii. Engagement with local community leaders, residents, family members and self-help groups to design sustainable ways to prevent violence, raise awareness about domestic violence, create networks of support and action within the community and advocate for women's rights.

iv. Conduct awareness activities like community dialogue, street plays, folk shows and stakeholder meetings to increase awareness of relevant rights and laws. Prominent men from the community, identified as male champions speak against intimate partner violence at these events.

Impact of Counselling on a Sex worker: **"Say a BIG NO"**

Prema lives in Bijapur and practices sex work on a part time basis. She was brought to Bijapur by her lover, who later forced her to go to an eatery on the highway and indulge in sex work. The reason was obviously money. Prema ensured the use of condoms with her clients but could never convince her lover to use condoms. Her lover soon lost all interest in her and abandoned her. During this time, Prema came across the intervention team and attended the counselling session. She was explained in detailed about violence by intimate partner, informed about the protective laws that exist to penalize domestic violence and the importance of use of condom during penetrative sex. Prema took a very strong stand with her intimate partner about the use of condom. She said the "BIG NO", let him go and accepted him only when he agreed to comply.

2.3. India Learning Network (ILN)

ILN is a project is to influence the global HIV prevention practice by disseminating widely the approaches & learnings that have evolved from scaled HIV prevention interventions in India. The project works to enhance the capacities of the programmers, policy makers and implementers from countries in Asia and Africa by facilitating exposure to the learnings and best practices from scaled HIV prevention interventions under 'Avahan', BMGF's India AIDS Initiative. The project deepens the dissemination of learnings by organizing learning site visits and offering in-country and on -site technical assistance and virtual learning support.

Funded by:
Bill & Melinda Gates Foundation

Project duration:
January, 2012 to March, 2015

Implementation Partners:
Family Health International (FHI) 360, University of Manitoba

Area of Work:
Asia (Bangladesh, Sri Lanka & Thailand)
Africa (Nigeria, Tanzania & Uganda)

2.3.1. Key Achievements and Activities under each project component

i. Guided Learning Visits:

The ILN team has conducted 128 visits till date, out of which 72 were learning visits and 56 were demonstration visits.

- Tier I Africa (Nigeria, Tanzania & Uganda):

The guided learning visits are organized to provide the participants an exposure to scaled HIV/AIDS programs in India. During these visits, the participants gain an opportunity to interact with representatives from the National Program, State AIDS Society (Karnataka), communities and stakeholders.

- Nigeria has had about 30 representatives visit India for learning visits and 11 representatives have been part of demonstration visits to India till March'14.
- Tanzania has had 14 representatives visit India for learning visits and 2 representatives for demonstration visits.

- Uganda had 8 members visit for learning visits
- Kenya, Zimbabwe and Indonesia had 47, 5, and 11 representatives for learning visits respectively.

"I was a part of the delegation that went for the Bridge Project guided learning visit to India in 2012 with other colleagues from United Nations, government officials from Ministry of Health and Uganda AIDS Commission, and members from non-governmnetal organisations.

The exposure to different aspects of MARPs programming we received, helped us on returning to Uganda to generate evidence, synthesis it and translate it into action at different levels.

Few months after we returned from India, we pushed for national mapping exercise for MARPs in Uganda at the Annual AIDS Joint Review 2012."

Rosemary Kindyomunda
National Programme Officer, UNFPA
Uganda

Learning Visits organized (ILN project)

Dates	Country	Organization	Number of members
13th -17th May 2013	Nigeria	9 State AIDS Control Societies and National AIDS Control program	18 member delegation
April 8th – 13th 2013	Kenya	Representatives from NASCOP and Kenya TSU	15 member delegation
1st – 5th July 2013	Nigeria	representatives from USAID implementing agencies and Sex workers network	10 member delegation
23rd-27th September 2013	Kenya	Kenya AIDS Control Program, NASCOP TSU	20 member delegation
28th October -1st November 2013	Zimbabwe	representatives from National AIDS Control Council, UNFPA and NGOs	5 members
28th October -1st November 2013	Kenya	representatives from Federal and county offices including NGOs and MOH	14 members
November 4th – 8th 2013	Indonesia	Indonesia AIDS Control office, Ministry of Health, State AIDS Societies, NGOs and UNAIDS	A 11 member delegation

Image no. 6. Delegates taken to watch a street play as a part of intervention of Trucker

Image no. 7. Delegates from Society for Family Health (SFH), Nigeria taken for demonstration visit to the Link Worker Scheme Project

Image no. 8. Delegates taken for a visit to KIMS OST Centre

ii. Technical Assistance Provided:

- Tier I Africa (Nigeria, Tanzania & Uganda):

As per requests from the Tier I countries, the ILN team has extended technical assistance towards the comprehensive documentation and feedback generation of the following documents:

Nigeria

- FSW Guidelines, National Strategic Plans, Outreach Protocols.
- Concept Note on the importance of developing Learning/ Demonstration Sites.

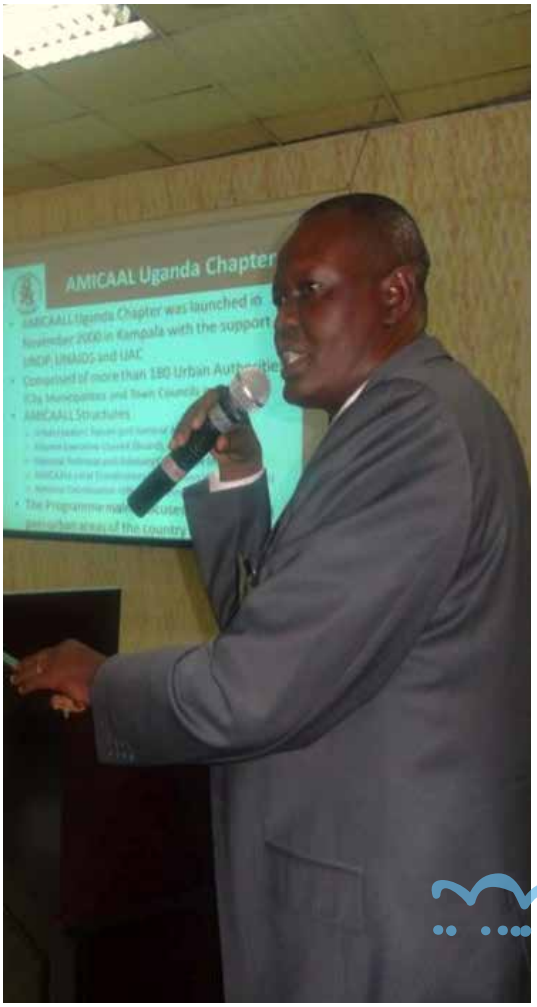
Tanzania:

- Review of Key Population - National Multi-sectorial Strategic Framework III for Tanzania.

- Community mobilization workshop for CBOs in partnership with UNAIDS.
- Development of CoC and GBV protocols and SOPs.
- Midterm review of the Zanzibar National Strategic Plan II.

Uganda:

- Mapping of MARPS in Kampala city in partnership with Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL).



"If we had not got the kind of technical support that we got from India Learning Network, the process of mapping and size estimation of key populations that we undertook would have been a great challenge for us.

Our colleagues from India came to help us begin the exercise. They came when we were doing our first level mapping. They came when we were doing the analysis. They were here to help us finalise the report. Now they are back to support us to review what we have done so far and help us come up with a bigger intervention now that we know our denominators.

This has really been a 'joint' effort, really."

Dr. John Mugisa
Country Director
Alliance of Mayors and Municipal Leaders
on HIV/AIDS (AMICAALL)
Uganda

- Development of M&E Systems and Clinical Formats support provided to the MARPI Initiative.
- Support to MARPS network in the supplementary Proposal writing for Global Fund, on the need for funding community initiatives.
- Concept note on development of Learning Sites shared with UN.

- Tier II Asia (Thailand, Bangladesh & Sri Lanka):

The ILN provided the following technical assistance to the Tier II countries:

- Coordinated and provided technical assistance towards the launch of the National Guidelines for Implementing HIV Prevention among Men who have sex with Men & Transgender Populations launched in Bangkok in April 2014.

iii. 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 member countries.

The activities were:

- **E-forums:** UoM introduced participants from all Tier I & II countries to the Google Groups e-forums. The forum has had discussion on issues related to **micro planning, peer led outreach, mapping techniques, community mobilization.**

The following topics were covered in **E-learning forums from April'13 to March'14:**

- Violence and Harassment against sex workers, violence addressing mechanisms and country response
- Development of Community Groups/Self Help groups/Community Affinity Groups
- Clinical Services for Most at Risk Populations
- Community Mobilization in the context of reducing HIV risk and vulnerability among Female Sex workers
- Setting up of Computerized MIS system
- Outreach Strategies and Approaches for IDUs/PWID populations
- Community Mobilization in the context of reducing HIV risk and vulnerability among Female Sex Workers
- Micro plan: A visual outreach management tool to improve, track and scale up coverage of interventions
- Peer led Outreach: Grass root strategies for HIV prevention among sex workers; Mapping technique

- E-tutorials - a series of online tests on completion of which participants receive certification. These are open not only to participants who attend/ have attend E-learning programs but largely to anyone who wishes to take up the tutorial on various thematic aspects of the HIV epidemic and vulnerabilities and also on Prevention, Care and Support for Most at risk populations.

The recent E-tutorial subjects cover topics like:

- Community Mobilization
- Outreach strategies for IDUs
- Clinical components for service delivery for MARPs
- Violence and harassment against sex workers
- Violence addressing mechanisms and country responses

- Webcast: UoM/ILN has developed webcasts on the following:
  - Micro planning
  - Community Mobilization
  - Outreach strategies for IDUs
  - Clinical components for service delivery for MARPs
  - Violence and harassment against sex workers, violence addressing mechanisms and country responses

iv. Other accomplishments include:

- **Technical Assistance in formulation of National Policies and Guidelines:**
  - Thailand: National Guidelines for Implementing HIV Prevention among Men who have sex with Men & Transgender Populations

- Nigeria: National HIV/AIDS Prevention Plan 2014-2015 National Guidelines for Implementation of HIV Prevention Programs for Female Sex Workers in Nigeria

- Tanzania: Midterm Review of the Zanzibar National Strategic Plan II

- **NGO Programs**

  - Nigeria: Micro planning workshops for Peer Educators with SFH

  - Tanzania: Capacity building on Community Mobilization for 17 CBOs Uganda: Mapping and Size Estimation of the Key Affected Populations in Kampala Capital City Authority with AMICAALL

- **UN Systems**

  - Tanzania: Supporting UNAIDS in their Community Mobilization initiatives.

  - Zanzibar: Supporting UNDP in midterm review of ZNSP

  - South Africa: Workshop on developing regional strategies for MARPS

2.3.2. Online and offline documentation

UoM/ILN team has developed:

1. A film on Community to Community Learning Systems.

2. Brochure on ILN-Bridge Project.

3. E-poster was prepared for ICAAP and oral presentation on Bridging Africa and Asia to Reach Zero NewInfections.

4. A session was delivered on Issues related to Key Population Programming in Africa for ICASA 2013 in Cape Town, South Africa. Co-laterals like poster, standee were prepared and designed by the team for the same event.

DOCUMENTS PUBLISHED:

List of documents which were initiated and printed in 2013-14 under Sankalp project:

1. The pillars of a national HIV prevention response – A guide for national program managers.
2. Combination HIV prevention with Most at Risk Populations – Avahan India's Sankalp experience.

Online Resource Directory:

Odom/ILN has compiled resources related to Avahan program in Karnataka and shared the same with Pop Council to be put onto the India HIV portal.

- HIV Portal: The online portal has been initiated and is accessible via the following link www.indiahiv.org.

2.3.4. Innovation

The E-learning program is an innovation of the ILN-Bridge Project where by the use of technology /internet, learnings on core HIV thematic areas and the Avahan experiences are disseminated to learners online in different countries.

It was an enriching experience to represent the transgender community from Kenya in the learning visit to India where I saw how structured and organized the transgender CBOs are here.

- Wangare Muruga,
Jinsiangu, Kenya

I work in the HIV program for young people in my country and the lessons I have acquired here in India : microplanning for FSWs, empowerment of the peer educators, volunteers and local leaders in the HIV prevention, willl help us in Indonesia to make our programme better.

- Yayu Mukaromah, Youth PMTS,
National AIDS Commission,
Indonesia.

2.4. Samvedana: Addressing Violence against Women in sex work in Karnataka

Samvedana project attempts to build capacities of CBOs and their members, strengthen the violence response system, build an enabling environment and sensitize the police, judiciary, media and Department for Women and Child Development (DWCD).

The **goal** of the project is to **"create an inclusive society free from violence against women in sex work in Karnataka".**

Funded by:
United Nations Trust Fund (UN Women)

Project Duration:
30th November'11 to July'15

Implementing Partners:
16 CBOs are implementing the project in 15 districts in Karnataka.

In collaboration with:
National Law School of India University, Karnataka State AIDS Prevention Society, National Institute of Mental Health & Neuro Sciences (NIMHANS).Centre for Advocacy & Research (CFAR), Community-based organization for women in sex work.

2.4.1. Key accomplishments of the project

i. Impact of the training and counselling on women in sex work and their intimate partners.

Women in sex work have now started seeking access to counselling for themselves and their intimate partners. Counselling is also offered in groups, which serves to be instrumental in making it easier for sex workers to collectively discuss the issues they face and learn from experiences that others share. Over time, these women are seen to evolve with renewed confidence to deal with situations of violence from intimate partners and also safeguard themselves from situations that de-mean their existence. Intimate Partners of the sex workers are counselled on issues like domestic violence, practice of unprotected sex by force. They are also made aware of the Domestic Violence Act under the Indian Penal Code. To address the issue of IPs staying away from the sex workers most of the times, the counsellors conduct events and sessions to accommodate and address IPs at regular intervals.

Image no. 10. Counselling session for a community woman at a Community based organization

Impact of the training module on
Negotiation Skills of Females Sex workers.

Mishba Parveen, is a sex worker, in one of the urban sites of Bijapur, Karnataka. She had recently reported a complaint in the police station for her lost mobile phone. A couple of days later a male police constable visited her residence, apparently to enquire about the lost mobile phone. Without showing much interest in the complaint placed by her, he started asking her uncomfortable questions like why she practices sex work. The constable accused her of practicing illegal activities in the locality owing to which she will have to accompany him to the police station immediately. Mishba, clearly understood that this man was not reliable and refused to accompany him to the police station. She questioned the policeman to show her the arrest warrant on the basis of which she will be legal bound to go to the police station at such a late hour. The policeman managed to call over another constable with a warrant. Even then, Mishba managed to refrain from going with the two police men alone.

She told that she will come to the police station the next morning with some of her female friends. To this, the police failed to pursue any further
as this is a legal protocol.

Mishba was one of the women who made good use of the knowledge imparted during the training on a module on “What to do when you get arrested”.

Image no. 11. A member of CBO in Bagewadi taluk of Bijapur availing services of Family counselling center

Image no. 12. Support group involved in a modular training at Kanaakal Village.

The women in sex work, after attending the modular training have started questioning violence, fighting for their rights, using safety plans to avoid violence.

- Impact of "Safety Plan" modular training - Assertive and self-defensive attitude among women after attending the training. The impact of this not only shows among those women who attend the training but it is largely seen to reach others in the community by word of mouth.

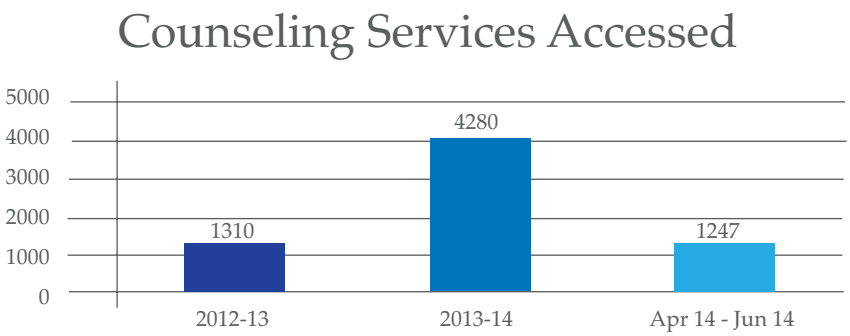
- Impact of the training on property rights - The training has imparted the much needed clarification on the various misconceptions about property rights for women. A great number of women agree to the second marriage of their husband while they are living, just to ensure that they have a legal male heir in the family. This is a result of the misconception that women- as daughters or wives are not entitled to any claim on the family property to husbands' property. Women who attended the training are now seen to write property for their daughters, claim right on husband's property after his death. Another positive impact is seen in growing rates of sex workers legally marrying, as they are now aware of their right to the husband's property which is a significant sense of security.

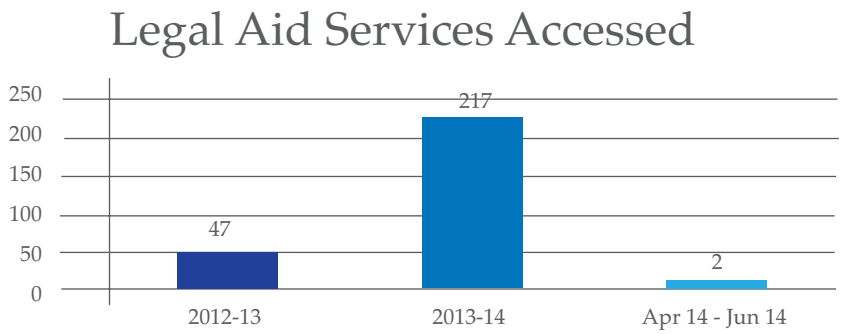
ii. Crisis Management Team (CMT)

All the CBOs have an active Crisis Management Team, trained on handling violence faced by women in sex work. Each of the intervention districts has a CMT at the taluk level and district level. It is ensured that the CMT at district level is in very close proximity to target group of community women.

Every case of violence reported is attended within 24 hours depending on the geographic proximity. In rare cases, if the CMT is unable to physically reach the crisis location, a peer educator is sent immediately.

The CMT also addresses cases that are referred to them by an acquaintance of the woman who is facing violence.





The graphs above reflect that Counselling and Legal Aid are two of the most accessed services.

The CMT members have also extended their support in conducting workshops for other civil society organizations working on key strategies to ensure safety for women facing violence.

iii. Channelize women towards Income generation schemes of the Government

Community members who experience violence have been referred for accessing government schemes that provide loans to start up small scale industries for income generation. 73 women have received loans through this scheme for starting up small scale tailoring units, stitching schools, sheep and goat rearing, etc.

Image no. 13. Sheep rearing is one of the popular livelihood options for women in Sex Work.

iv. Encourage women to start Saving money

Two community based organizations have started their own cooperative banks to help women initiate saving plans.

Image no. 14. CBO AJMS official in discussion with community women to promote savings and deposits in the cooperative

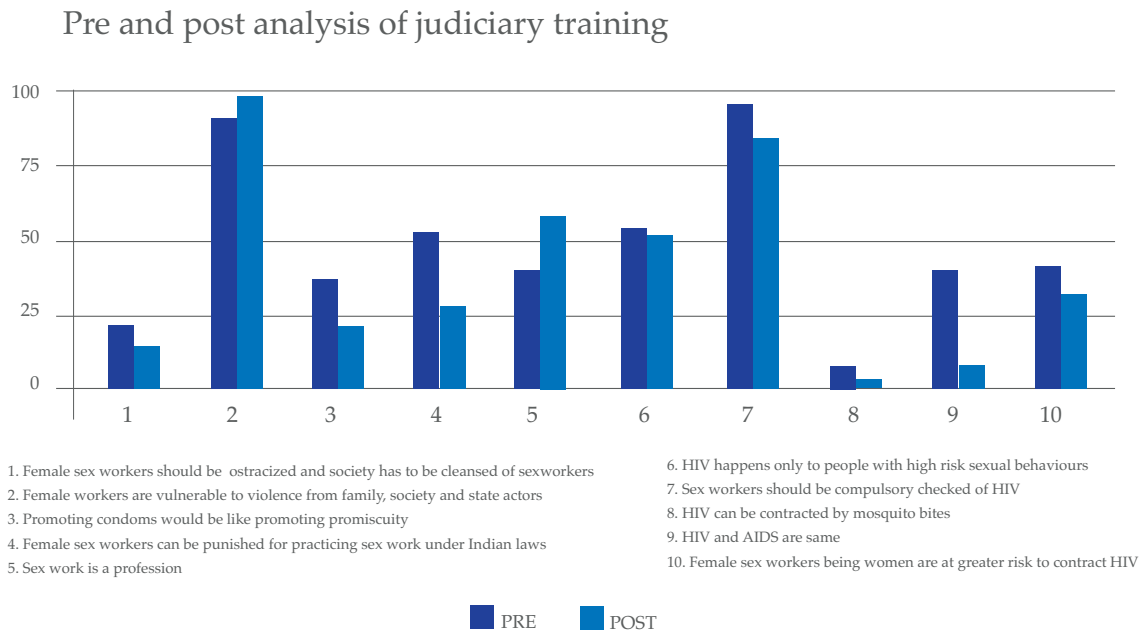
v. Involve Judicial Officers to lay down a strong foundation to prevent Violence against Women

96 Judicial Officers have partnered with the Karnataka Judicial Academy and National Law School. After the Sensitization workshop, there has been outstanding impact on the judicial officer's attitude towards women in sex work.

A total number of 307 police men have been sensitized on issues of VAW in sex work and its interface with HIV.

Image no. 15. Police Sensitization Programs

- DGP has assured regular deputation of police personnel to attend the police training in all the focused districts.
- The Police Commissioner of Bangalore agreed to conduct training in all the 110 police stations under his jurisdiction. This is a record of sorts, considering there was no police training in Bangalore urban district in the recent past.
- Superintendent of Police, the top most official of the district has been attending the inaugural function of the judiciary training and gives a commitment to the CBO to help them in their endeavours.
- The interaction between the CBO and Police has improved.
- The police related violence has dropped from 6% in Nov'13 to 3% in May 14.



The district judges from some districts have been proactive to facilitate sensitization workshops for all frontline police personnel and station heads.

Sixteen women have been trained by the judicial system in the district as Para Legal forces and have been issued identity cards from the district legal authority.

Key activities

1. Module based trainings to address issues faced by women in sex work

Completion of training based on the first seven modules designed under Samvedana reflects visible patterns of understanding, acknowledging violence they face, being proactive to report the violence, take actions against it unlike the past by women in sex work in all 15 intervention districts in the state of Karnataka and its subsequent interface with HIV.

The next step is the roll out of the next set of modules (Module 8-15) which cover the following subjects:

- Importance of will writing
- Saving and credit interest rates

- Communication skills - Negotiation & assertiveness
- Property rights and tenancy Laws
- Influence of violence on children and protection
- Divorce, maintenance and custody of children
- Legal services
- Stigma and Discrimination

2. Orientation of Community Leader to violence against women (VAW)

Community leaders from all non-intervention districts in Karnataka were consulted and oriented on Violence against women. During the workshop, laws pertaining to women in sex work, Domestic Violence Act, Crisis Management Team - the concept and its functions and an in depth session on violence against women and its interface with HIV have been covered.

3. Workshop for media Personnel

Karnataka Health Promotion Trust along with the Centre for Advocacy and Research conducted media workshops in various intervention districts including a state level media workshop covering 75 media personnel. The sensitized group of journalists volunteered to document the positive impact of efforts made by community based organizations to organize blood donation camps, protest march against atrocities faced by all women and young girls.

4. Monthly sessions

Monthly group sessions are organized for support groups and self-help groups by trained community facilitators on the 15 modules developed based on the community's needs.

5. Group Reflection Activity

To track the awareness levels and attitudinal changes among sex workers a group

reflection activity has been initiated for the intervention in two districts of north Karnataka on Intimate Partner Violence (IPV).

The intimate partners (IP) of women in sex work and women attend group sessions built on the various aspects of relationship between the IP and women in sex work. These group sessions also act as reflection sessions.

6. Advocacy with State Institutions

Samvedana maintains regular advocacy with State institutions like the Judiciary, Women and Child Department so as to ensure interaction between women in sex work and these institutions.

- The CBOs have been able to mobilize communities of women in sex work towards to engagement in constructive efforts to development. A growing trend is observed among women in sex work coming up in the roles of Accredited Social Health Activist (ASHAs), (frontline health workers). They provide Mother and neonatal child health services at the village level. CBOs are encouraged to promote this with the Village Panchayat. This is a positive development in not only reducing stigma but also in providing Mother and Neo natal and Child Health services (MNCH) to the pregnant women of the community.

- ASHAs at a later stage are being trained as resource persons for modular training.

- CBOs are taking lead in coalition meetings locally. They have brought NGOs working on various issues to a common platform for discussion. It is gradually becoming a hub of communication and discussion. Be it a CBO of FSWs or People living with HIV, Orphan and Vulnerable Children, Ujjwala Home, Childline, they are seen supporting each other on different issues to make a positive impact. In course of time, this would strengthen the collectivization of CBOs with different objectives. This has also lead to a good exchange of skill sets and capacity building. SSWs with good training skills are now appointed as resource persons for other NGOs on gender, violence, legal rights and HIV/AIDS trainings.

- As an outcome of state level coalition meeting, India Literacy Project (ILP) an NGO working on educational and mentoring support to needy children,

has come forward to extend services in two districts. They are offering their mentoring support to children by opening multi-dimensional learning Space Centre to the children of community members who are studying in Government schools.

- ILP has also come forward to offer limited number of scholarships to the children who are studying in High school and above.

Knowledge Sharing & Innovation

KHPT has shared the learnings and strategies of Samvedana project with 11 countries through an E- forum. These countries include Uganda, Tanzania, Nigeria, Kenya, Ethiopia, Mozambique, Ghana, Indonesia, Zimbabwe, Sri Lanka and Bangladesh.

2.4.5. Strengthening Health Outcomes in Private Sector (SHOPS) Tuberculosis Prevention and Care Initiative in Karnataka

The project works with the urban slum population and private health care providers in the intervention districts/ towns. It is based on the PPIA (Private Provider Interface Agency) model. The primary objective of the project is to increase the participation of private health care providers in TB prevention and care activities by enabling them to practice standards of TB diagnosis and treatment, facilitate early detection, treatment initiation and increased adherence among the TB patients. Project covers 42 towns across 12 districts in Karnataka.

Funded by:
United State Agency for International Development (USAID)

Project duration:
April'13 to March'14.

Implemented by:
KHPT in Karnataka

Lead implementation partner:
Abt. Associates Inc.

The project has reached about 2.5 lakh individuals through community outreach to promote awareness of TB symptoms and testing at proper centres. Around 4200 health care providers of all types have been mapped and around 1850 providers were trained on pertinent topics. About 1500 health care providers have been networked with the project and confirmed adoption of standard principles of TB management. Project has contributed to diagnose more than 3000 TB patients among them, 1337 are under RNTCP and remaining patients are receiving care under private sector. Five private medical colleges are engaged as a sustainable platform for provider training and Karnataka Medical Council has accredited the TB trainings as continuing medical education for practitioners of modern medicine.

Key outcomes:

Private Sector

- Improved relationship with patients and their families
- Community recognition

- Patient retention
- Increase in knowledge about TB and its management
- Professional growth
- Fulfilment of a healthcare provider's public health responsibilities

Public sector

- Improved TB notification
- Increased penetration of RNTCP among healthcare professionals and community
- Decreased delay in TB diagnosis and initiation of treatment
- Additional resources in public health

Patient and Community

- Lowered morbidity, mortality and economic losses among people suffering from or affected by TB
- Access to healthcare providers of their choice
- Improved health seeking behaviour
- Higher quality healthcare services

The key results expected from the initiative includes - increase in TB notification, high levels of treatment compliance among TB patients treated by private providers and decrease in private provider and health system delays in TB diagnosis and initiation of treatment.

Key Activities

1. Communication and Outreach activities

Communication activities have played an instrumental role in prevention and management of health issues having prolonged treatment period like Tuberculosis (TB), where treatment adherence is linked to quality of life and issues of drug resistance.

Purpose

- Bring about positive change in health seeking behaviour,
- facilitate social change process for increasing community participation,
- address stigma & discrimination, myths & misconceptions,
- promote awareness about symptoms of TB,
- assess standard diagnostic facilities for TB detection and treatment services.

Community-based TB activities also contribute to prevention, diagnosis, improved treatment adherence and care that positively influence the outcomes of drug-sensitive, drug resistant and HIV-associated TB.

Process

Communication tools and methodology are developed considering pattern of human gatherings like interaction with single individuals, small group and large group meetings, events and occasions and for public screening covering various themes.

A. Outreach Workers

- ORWs serve as Inter-Personal Communication (IPC) agents. They are trained to perform communication activities, active case detection, facilitate sputum collection and provide Care and Support services.

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Image no. 16. In-person visits by Outreach Workers

- ORW serve as frontline health workers directly engaged with slum based community members and conduct communication and care and support related activities for TB prevention and treatment.

- ORW reach community members through interpersonal communication, small group and large group meetings through meetings and special community level events like World TB day.

B. Interpersonal Communication

- IC is ensured by the ORW at various aggregation points through house visits. It helps to improve access to essential services for diagnosis and treatment of TB.

C. Small Group Meetings

- Animation movie, leaflets, brochures are used to educate the community groups during these meetings.

- ORWs conduct these meetings and discussions to address the challenge of low levels of knowledge around TB among the target group.

- ORW addresses TB symptoms, duration of treatment, location of nearest treatment centres, barriers to accessing TB services, such as stigma and discrimination, and emphasize that TB is curable.

D. Large Group Meetings and events

- Awareness campaigns and large group meetings are significant to form positive community opinion towards issues affecting themselves and facilitating of endogenous social learning processes.

Image no. 17. Large group meetings conducted in Gulbarga

- The ORW ensures establishment of information kiosks, and usage of audio-visual materials like animation movie, feature film and informative display material like banners, posters and brochure to provide information about TB, popularise DOTS *Mitre* helpline, diagnostic and treatment facilities.
- The following materials are used in the communication activity in the slums:
  - Flash card
  - Leaflets
  - Posters
  - Films
  - Movies – Short Documentary and Animated clip
  - Banners
  - Hoarding

Image no. 18a. Use of posters and distribution of leaflets to spread TB awareness

Image no. 18b. Screening of a documentary called Akshaya to spread awareness on TB among community members

2. Capacity Building

Purpose:

- Identification and mapping of preferred healthcare providers.
- Orientation of service providers likely to be engaged in TB management.
- Training of clinicians, pharmacists, laboratories, assistants to clinicians and community volunteers.
- Creation of network with continued support through (a) mobile phone-based quizzes for self-learning, (b) exchange forums for cross-learning and (c) supportive visits by the Public Private Interface Agencies (PPIA) staff.
- Support from medical college faculty and Continuum for Medical Education (CME) for continued learning.

Process:

CB activities can be broadly categorised into the following activities:

- Mapping
- Orientation
- Training
- Networking
- Network support

A. Mapping:

Mapping is to be carried out of all the healthcare facilities and resources based on the criteria developed in the project areas. This activity provides a clear picture of the magnitude of the healthcare resources present in and around the project areas.

B. Orientation:

The pHCPs are screened and their eligibility for orientation is assessed. On successful short listing, the pHCPs are oriented regarding the project. Their continued participation in the project is then ensured.

C. Training:

Successfully oriented pHCPs are invited to attend the training activities. Trainings maybe conducted in one of two methods:

Image no. 19. Personal Clinic Assistance (PCA) Training

i. classroom training intended for large groups

ii. In-clinic trainings for pHCPs who are unable or unwilling to attend classroom trainings. The specific tools that are developed for each type of pHCP are used to conduct these trainings.

D. Networking:

After the completion of training, all willing pHCPs are networked into project Networking requires that the pHCP signs a document accepting to be a part of a network of pHCPs who adheres to the standards of TB care as outlined by the project. This activity entails the visit of NC/TC/TS to the pHCP. Project staff explains to the pHCP what networking entails and obtain their signature on the networking document.

E. Network Support:

Once networking of pHCP is completed, the project continues to support them in the form of Network Support activities. Experts from medical colleges and TS/ TC address the existing gaps in the knowledge and skills of pHCP during these visits. Support visits seek to ensure 'transfer of learning', defined as ensuring that knowledge and skills acquired during a learning intervention are applied on the job. In addition, KHPT proposes to engage with the District TB Officers (DTO) and other RNTCP officials to resolve any operational issues.

3. Care and Support:

It is very important to develop a treatment partnership with the patient for the successful completion of the treatment by focusing on patient's concerns and priorities.

Five A's are used which are:

i. Assess
ii. Advice
iii. Agree
iv. Assist
v. Arrange

Care and Support activities comprises of two parts which is Pre-Diagnosis and Post-Diagnosis. The patients are supported, followed and credited till favourable outcome of treatment is achieved. Also, the patients are provided with quality services and provider of their choice.

Purpose:

- Increase the case detection rate among the target population.
- Reduce the delay in diagnosis and treatment initiation.
- Provide counselling to patients.
- Ensure universal coverage of all types of TB.
- Influence treatment outcome by improving treatment compliance.
- Promote case notification to RNTCP.

Process:

Pre-Diagnosis:

- Identification of symptomatic cases: One to One Slum visit is done to impart information on Tuberculosis, its symptoms and treatment.
- Targeted screening of vulnerable population sub-groups: Patients are identified and any other information on TB suspects is collected. Duration of the symptoms is noted (if any).
- Empowered referral to laboratory investigation: For any suspects, they are referred to government or put to testing sputum. In case of negative sputum test X-Ray is checked and other testing methodologies are employed. Also, facilitate sputum testing at the DMC.
- Information on cough hygiene and other preventive measures are explained to the slum population.

Post-Diagnosis:

1. A TB patient undergoes following three steps after he is diagnosed with the disease:

i. Denial (of the disease)

ii. Acceptance

iii. Fear

2. Treatment Initiation Support: The patient is provided with the Pre-counselling and treatment facilities. This converts the patient's denial of the disease to acceptance, overcoming fear and finally action that is incorporating changes in lifestyle, nutrition and coping with family.

3. Treatment support services- counselling, side-effect management, Sputum Collection and Transportation, Prerana Support Group meeting, DOTS Mitra care line.

i. Sputum collection and transportation:

Purpose:

- Increase case detection rate among the target population.
- Reduce the delay in diagnosis and treatment initiation.
- Promote and facilitate case notification to RNTCP.

ii. DOTS *Prerana* support group meeting:

Image no. 20. Patients sharing their experiences during Prerana Group Meeting

Purpose:

- To strengthen the TB patients to better cope with situations and conditions which they face in daily life and to empower them for sustainable health seeking behaviour through improvised treatment adherence.

- To provide information about essential requirements and detailed processes on conducting *Prerana* Support Group meetings with TB patients.

iii. DOTS *Mitra*:

Provides counselling service, reassurance and referral to the treating clinician

Image no. 21. Counselling provided by a Mitra Care line operator

Purpose:

- Support TB patients unwilling for DOTS.

- Help non-DOTS patients to improve adherence among a community of patients who are considered to be unknown to national program and considered to have high levels of treatment non-compliance and therefore susceptible of developing drug resistance.

- Promote through networked pHCP who initiate TB patients on anti TB treatment.

4. Monitoring and Evaluation:

The M&E plan is developed with the coordination of state level project team and key stakeholders. The role of this M&E function is to guide and coordinate programme design, monitoring and evaluation of entire programmes by providing technical support in survey, research, programme design, planning, monitoring and evaluation and transition as well as developing other tools for improved quality of assurance.

The Design, Monitoring and Evaluation function includes broadly the following activities.

- Program design at all levels and capturing the related data using web MIS
- Monitoring of all programmes and reporting
- Quality assessment tools
- All types of evaluations including the mid-term and final evaluation or any other evaluation that may be required by management or any other as may be requested by a stakeholder.

5. Advocacy:

Purpose

- Advocacy improves case detection and treatment adherence by combating stigma and discrimination and empowering individuals and communities to mobilise political commitment and resources for Tuberculosis.

- Supports specific objectives for interventions for TB or other program components to address the social, cultural, financial and psychological barriers to successful implementation.

- Tuberculosis advocacy has gained strength as a mechanism to increase access to new methods to fight tuberculosis and involve communities in policy and programmatic decisions.

- The survivors of Tuberculosis or other people affected by the disease have served as public voices for it, partly because of its curable nature, and efforts for tuberculosis control.

Innovative initiatives under shops tb prevention and care project

1. **Empowered referral to laboratory investigation:** During the communication activities persons with symptoms of TB are counselled and made aware about the symptoms of TB, investigation and treatment. They are offered with a range of available options to choose from to undergo testing like linking to closest networked private healthcare providers, Sputum Collection Agency, Private accredited lab or DMC. They are referred to most appropriate investigation facility depending on the convenience of the patient.

2. **Prerana Support Group:** Project has established *Prerana* (meaning 'inspiration') support groups of TB patients in each of the intervention town. *Prerana* group meeting are by the peer group and for the peer group. The group consists of TB patients, family members and those who have completed treatment successfully. Meetings are facilitated by program personnel, Local leaders, Anganwadi workers and public health personnel are also engaged as facilitators of *Prerana* Group Meetings. Experience sharing and deliberations of the group has huge impact on the patients in addressing psychosocial challenges faced by the patients.

3. **Mobile based self-learning tool for clinicians:** Objective of the mobile based self-learning tool for clinicians is to assess the acceptance to use innovative approaches like quiz programs for self-learning among qualified and non-qualified pHCP to use innovative approaches. The quiz application is a set of questions divided as different modules based on different topics. Answers keyed in by the users are batched and sent anonymously to the server through SMS for analysis. Quiz application was installed on the mobile phones of the pHCP who were willing to participate.

Image no. 22. Installation of quiz applications at PHCP

Stigma and Discrimination: Two sides of the same coin

"I don't want to live anymore. My husband never came out to look out for me. What should I do now?" says Nagamma, a mid-wife diagnosed with Tuberculosis. She had to suffer a lot of discrimination when her family and community came to know of it. She was thrown out of the house by her mother-in-law and isolated by the community when her TB status was revealed. Her husband considered her to be cursed!

The SHOPS Outreach team during one of their follow up home visits heard about Nagamma's case from the community. They immediately visited her and motivated her to continue the treatment and take all medicines without fail. They heard Nagamma's plight of being thrown out of the house. The outreach team then visits Nagamma's family. Initially, her mother-in law and husband were highly reluctant to speak to the outreach workers and avoided them. After persistent efforts made by the team, the family listened what they had to say, The family was informed that TB is completely curable and that the patient can prevent spreading the disease by following some basic cough hygiene practices. They were also informed that TB treatment is available free of cost at the government hospitals. The outreach team assured to family that they will assist Nagamma's family through the treatment period. They were also invited to attend the support group meeting known as the "Prerana Group Meeting" every month. Nagamma's mother-in-law confessed that after speaking to the outreach team and attending the Prerana group meeting all her misconceptions were cleared. She brought Nagamma back to the house and helped her adhere to medication.

Nagamma and her family are very thankful to the SHOPS TB team for all Care and Support that they extended.

4. **Dots Mitra Care line:** A telephone based care line (called Mitra) service was initiated to primarily support TB patients unwilling for DOTS. The service helped non-DOTS patients to improve adherence among a community of patients who were considered to be unknown to the national program and considered to have high levels of treatment non-compliance and therefore susceptible to develop drug-resistance. The initiative is promoted through the networked pHCP who initiate TB patients on anti TB treatment (ATT). pHCP provides basic information about the Mitra service and advises to contact Mitra care line service by giving a missed call by their mobile phones.


DOTS
Pura course / Pakka ilaaj

field diaries

DOTS Mitra Care Line: The **real care giver.**

Meera, lives in the Bellary district of Karnataka. She is 21 years old. Off late Meera was suffering due to ill health and the symptoms included chest pain, continuous coughing, loss of weight and weakness that held her from going to work. She came across a poster at the Aangan wadi centre which stated that, "cough more than two weeks can be TB". She immediately told her husband about it and decided to visit the hospital the very next day. The doctor asked her to go for the sputum test and she was soon diagnosed with Tuberculosis. She became highly anxious after knowing that she was suffering from TB, she was worried as to how her husband will react to it and discussed this with the doctor. The doctor gave her the Mitra Telephone Care line Card and told her that she could give a missed call on the toll free number. Meera was called back immediately after she a missed call. The lady from the care line began by asking some basic questions and registered her on the care line. The counsellor motivated Meera that complete adherence to medication coupled with healthy diet cures TB completely. She was also explained about ways to deal with side effects of high dosage of medicines. The risk of transmission to family members can be reduced by following some cough hygiene practices. Meera says, "Mitra Care line has been very supportive throughout my treatment. Mitra is the real care giver".

Meera now shows a keen interest to become a counsellor at Mitra Care Line and convey the message that "TB is curable".

2.6. Vihaan

Vihaan means 'First light of Dawn' in Sanskrit works. The project works towards complementing the national government's programme for care, support and treatment services for people living with HIV (PLHIV). To increase the rate of adherence among PLHIV, KHPT is implementing the project in all the 30 districts in Karnataka, through 27 Care & Support Centres and 3 help desks.

Funded by:
Global Fund

Timeline:
1st April 2013-31st March 2016

Principal Recipient:
Global Fund, Alliance.

Sub Recipient:
Karnataka Health Promotion Trust (for Karnataka)

Sub -sub recipients:
District level networks of positive people and few non-governmental organizations.

2.6.1. Key Accomplishments

Quantitative Reflection of Progress

Key Achievements:

Indicator No.	Core Indicator Description	Intended Targets			Actual Results			% of Achievement
		Till Previous Reporting Period	During Reporting Period	Cumulative	Till previous Reporting Period	During Reporting Period	Cumulative	
1.1	No of PR, SR, SSR and the service providers trained on programme, monitoring & evaluation and finance management and on different thematic areas.	900	173	1,073	295	126	**421**	**39%**

1.2	No of Care and Support Centre Established	27		27	27		**27**	**100%**
1.3	No of PLHIVs registered in ART Centre and on ART are registered in the CSC	-	1,02,935	1,02,935	28,518	10,116	**38,634**	**38%**
1.4	No of PLHIV in Pre ART phase who get registered at the CSC	-	51,782	51,782	8,270	3,138	**11,408**	**22%**
1.5	No of registered PLHIVs receiving at least one counselling service in the quarter	36,788	13,254	50,042	15,461	5,358	**20,819**	**42%**
1.6	No of registered PLHIVs receiving at least one counselling session on thematic areas	36,788	13,254	50,042	18,140	5,306	**23,446**	**47%**
1.7	No of PLHIV whose at least one family member or sexual partner referred for HIV testing and received test result	904	305	1,209	526	222	**748**	**62%**
1.8	No of PLHIV registered in the CSC linked to Govt. social welfare scheme	36,788	13,254	50,042	5,012	2,373	**7,385**	**15%**
1.9	Proportion of PLHIV lost to follow up (LFU) brought back to treatment	43,704	40,917	84,621	3,790	2,911	**6,701**	**8%**

1.10	No of Advocacy meeting organised	81	27	108	48	27	**75**	**69%**
1.11	No of helpdesks established	3	-	3	3	-	**3**	**100%**

Registrations

Family Details	
Total number of families registered	23903
Number of families –Widow headed	6929
Number of families with two PLHIVs	6202
Number of families with both parents expired	1633
Number of family members eligible for HIV testing	1546
Referred for Testing	984
Tested	686

TB Testing	
Referred for TB Testing	529
Number of PLHIV Tested for TB	500
Number of PLHIV found positive after Test	97
Number of families where both parents have expired	1633
Number of PLHIV receiving treatment for TB	500
Number of PLHIV who have completed treatment for TB	379

Details of HIV Testing	
Number of family members eligible of HIV testing	1546
Referred for Testing	984
Number of individuals tested for HIV	686

2.6.2. Key program initiatives and its impact

1. Chinnara Chilipili:

Chinnara Chilipili is a workshop envisaged to usher in a positive behaviour change and an enhanced sense of the self and surroundings among children living with HIV (CLHIV). The games and interactive sessions are designed so as to develop some of the primary life skills like empathy, effective communication, creative thinking, problem solving, awareness about the self, interpersonal relationship building, stress and emotion management, decision making capacity of these children.

The KHPT MAC AIDS' programme has provided the financial support to organize the workshop in seven districts which covered a total number of 224 children in the program. A total 444 children have participated in the program till Feb 2014. Increasing number of requests are coming from the CSCs for such workshops, owing to which the program is further extended and expanded.

Image no. 23. Clay modelling session at Chinnara Chilipili workshop

Image no. 24. Group activities at Chinnara Chilipili workshop

2. Trainings (PR/SR/SSR level):

Thematic trainings have been conducted for 26 Project Coordinators from the SSR. Three batches of trainings have been organized for 100 ORWs.

3. ART and CSC Coordination meeting and data sharing:

Data is regularly shared between ART and CSC, with support from DAPCUs and CST team. The Pre-ART and ART LFU data has been shared on a regular basis with the CSCs through the DAPCU. A special intensified LFU tracking system has been initiated by KSAPS with the support from NACO.

4. Coordination mechanisms with stakeholders including TI and district health services:

Monthly coordination meetings are conducted at the CSCs level, between all partners in the district. During the monthly meeting, project specific activities are shared and special activities are discussed.

5. Support Group Meeting:

A total number of 13862 community members have participated in the support group meetings held. The support group meetings covered the following key thematic areas:

Basics of HIV	**126**
Basic health and Hygiene	**88**
Diet and nutrition	**147**
Home Based Care	**51**
OI management and co-infection	**102**
Treatment education /adherence	**192**
Social entitlements and livelihood	**211**
Positive prevention/ Positive living	**61**
Yoga and meditation	**27**
Side effects of ART and its management	**61**
Legal rights and referrals to legal aid	**14**
Safe sex education to all age groups except children including condom education	**39**
Disclosure issues- children /spouse	**19**
Stigma and Discrimination and GIPA	**19**
Peer Leaders/Positive Speaking	**11**

In Koppal, meetings have been conducted for discordant couples. Total 15 couples were present for the meeting.

These sessions include discussions on:

- importance of accepting the HIV status of partner/self,
- importance of extending care & support to each other rather than getting separated,
- importance of extending psychological support to strengthen the relationship,
- importance of meditation and ART,
- discussing the chances of opportunistic infections and their side effects,
- highlighting that HIV is a life long therapy, which once initiated should not be left abruptly,
- open discussion on condoms and benefit of regular usage of condoms; prevention of STIs, transmission of HIV and prevention of unwanted pregnancy.

Image no. 25. Meetings organized for discordant couples

6. The Global Fund Representatives visited KNP+ - Bangalore Urban CSC:

The following discussions took place:

- The CSC program, its implementation and the role of CSC in working with ART centres, strengthening access to services and linkages.
- The ORWs also shared their role in outreach, Micro plan, Vulnerability index, and geographical distribution of ORWs.
- The CSC staff shared about their job responsibilities and the key M&E documents developed and maintained in the program.

Image no. 26. Meeting at Bangalore Care & Support Centre

7. Coordination Meetings at the Districts (DC, CEO as well as DAPCU) :

- Meeting Organized and led by District Collector and CEO

  In Yadgir, District Coordination meeting was conducted with an objective to prevent new HIV infection, facilitation of linkages for PLHIVs and reduce stigma and discrimination. It was decided that the meeting will be organized once every quarter, to review the progress of key partners in addressing the same. Vihaan team has been given the following responsibilities to:

  - strengthen awareness among the key social welfare departments,
  - collect information on all schemes available for the community,

  The department heads were also asked to share the information with Vihaan team members. The Agriculture Department, SC/ST and Backward Corporation were requested to give preference to PLHIV for subsidized loans.

In **Koppal**, a program review meeting was organized under the leadership of District CEO. Vihaan team was present for the meeting to share the key objectives as well the progress of the Vihaan program in the districts. The CEO has appreciated the efforts and also suggested the departments that they should take lead in identifying key programs for the PLHIVs.

In **Bangalore Urban**, **Bellary, Shimoga, Chikkaballapur** and **Chamarajanagar,** DC meeting was conducted to review the gaps in the program and address the linkages for child protection programs, housing as well as linkages for widows.

- **DAPCU Meetings:** Once every month DAPCU meeting is conducted, to discuss the issues pertaining to LFU follow-up, collection of ART data.

8. Social entitlement and welfare schemes for PLHIV:

Total 3444 individuals have been linked to major schemes. Some of the key links that the PLHIV are linked to,are listed below:

Indira Gandhi Matritva Sahyog Yojana	23	Other Children Schemes	708
Other Education Support Scheme	156	Ration Card	7
Antyodaya Anna Yojana (AAY)	477	Aadhaar Card	13
Integrated Child Development Services Scheme (ICDS)	302	Caste Certificate	3
Other Nutritional Schemes	295	Birth Certificate	11
Indira Gandhi National Widow Pension Scheme (IGNWPS)	27	Death Certificate of Husband for Widow or Parents for Orphans	4
Other Pension Related Schemes	13	Marriage certificate	2
Janani Suraksha Yojana (JSY)	1	Income Certificate	7
Other Health Related Schemes	33	Bank Account	372

9. Advocacy with relevant Departments/Institutions:

Sl. No	Name of the Department/Institution	Results
1	Rajiv Gandhi Housing Corporation Ltd.	A total number of 160 shelter homes have been allotted in Bangalore Urban. The Social welfare department has agreed to support 107 members of SC.
2	Department of Women and Child	Resolved to address the gaps in the implementation of the OVC program.
3	Karnataka Women Commission	Resolved to address the issues faced by women and adolescent girls.
4	DAC	DAC has been initiated in few districts and will be initiated in the rest of the districts.

- **State Level Advocacy:** The State level advocacy meeting was conducted on 25th June'13 at Regional Cooperative Society, Bangalore with the following objectives to ensure:

  - the District Level Networks take lead to facilitate the Advocacy activities,
  - ownership by the Community in strengthening the advocacy process,
  - build interrelationship with government department at the district and state level, so that the advocacy remains a continued process and not a one-time event, which ensures to address the gaps in accessing services and sustains the efforts.

- **District Level Advocacy:**

Image no. 27. District Level advocacy meeting

At the district level, the focus of advocacy has been the health department, where in the major role of the CSC team has been in patient care and delivery services for HIV positive pregnant women, advocacy with FPAI for facilitating and conducting health camp and nutrition for pregnant women, advocacy with District collector and CEO for scaling for linkages, advocacy with Women and Child Development Department for addressing gaps in schemes pertaining to OVC children and women. The local MLA and donors met to support OVC children with education materials and books.

- **Advocacy Meeting:** An Advocacy meeting was held in Mysore, where the CSC took a lead in organizing the program to address the issues of women and children. THJe meeting was attended by around 105 PLHIVs from the community members from the Government department - Women and Child Development Department, DCPU (District Child Protective Unit), SVYM (Swamy Vivekanda youth movement), and Dr. Sriram from Asha Kiran.

10. Medical Camp

A medical camp was organized in Sonnanahalli, Kolar, by the CSC with the support of ICTC and DOT centre. The objective of the camp was early diagnosis of HIV and TB. 178 people attended the camp.

Image no. 28. Candle light procession organized by the Mysore CSC

11. Candle Light Procession

A candle light procession was organized in Mysore on 28th May'13 by the Care & Support Centre under the leadership of Dr. Raghu Kaumar, DAPCU. The day was observed to convey condolences to those who have lost their lives (due to HIV) and also to impart awareness among people about HIV.

Image no. 29.

12. Meeting with ICPS to address linkages of OVCs:

Government of Karnataka has formulated Integrated Child Protection Scheme which brings together existing multiple child protection schemes such as Juvenile Justice Programme, the Integrated Street Children, Adoption Process, Child Help Line Services, under one umbrella.

The main objectives of the scheme is to institutionalize essential services and strengthen structures, enhance capacities at all levels, create database and knowledge base for child protection services and strengthen child protection at family and community level.

In all the districts, a meeting with the ICPS unit was held to address the gaps and strengthen linkages for OVC schemes. In each of the districts, CSC team, along with KHPT, participated in the meeting, which is conducted on a regular basis to review the OVC lists, identify the gaps after which the CSCs take the lead in addressing the same.

13. Stigma and discrimination for PLHIV:

Number of stigma and discrimination cases have been reported, out of which 35 cases have been were being intervened by the CSCs. Cases of discrimination faced from family members and health facilities have been reported high. In all the districts, the DRS has been formed and they meet regularly.

14. Supportive Supervision Visits to SSR:

The SR Team has made 117 priority visits in order to focus on strengthening the coordination between NGOs, CBOs and ART center and On site Data Validation.

2.7. Place AIDS Programme (AIDS Fund)

MAC AIDS Programme works to create platforms for learning for children living with HIV (CLHIV) to increase the scope and effectiveness of the AIDS response. The program aims to enhance the quality of life of these children in institutional and community settings.

Funded by:
MAC AIDS Fund

Project Duration:
1st July'13 to June'15

Technical Partner:
INSA, India

Implementation Partner:
Sneha Care Home, Milana(Bangalore), Snehagram(Nachkuppam), Infant Jesus Children's Home (BLR), Jeevadaan, Snehasadan (Mangalore), Kutumb (Belguam), Nava Sanydhya Children Home, Namma Makkala Dhama (Bijapur), Asha Kirana (Mysore), Birds Heal,St. Luke Health Centre (Gulbarga), Mhesh Foundation, Nandana Makkala Dhama (Belguam)Kolar Outreach,Orbit (Bidar)

2.7.1. Activities and Accomplishments:

1. Champion in Me-2013- Sports and Arts Cultural Meet (District Level)

Intent/Rationale

Children living with HIV, in most cases live a life of intimidation that in a big way keep them in complete darkness about their inner strengths. They rarely get a chance to discover and unleash the "Champions" in them.

The "Champion in Me" is an initiative to give children a platform to discover and exhibit their latent potentials. This is seen to significantly enhance the psychological health of a child which remains dampened in the shackles of stigma and discrimination from family (in some cases) and society at large, magnifying the suffering that the epidemic brings to their lives.

The intent of this program is to induce in each child a belief that there is lot more in them than HIV / AIDS.

KHPT Place AIDS Programme conducted Champion In Me-2013- Sports and Arts Cultural Meet at 27 districts in collaboration with KHPT- Vihaan Project.

This program is a two day workshop, wherein children are encouraged to engage in cultural activities like singing, dancing, drama in the first day and the second day gives them a chance to participate in Sports like football.

Outcome

At the end of the two days, children judged at the district level and later 54 children were short listed to participate at the state level Champion in Me program organised in Bangalore.

2. Champion In Me-2013- Sports and Arts Cultural Meet (State Level)

KHPT- Place AIDS served as the key partner of Sneha Care Home to organise Champion In Me state level event on December 1st and 2nd 2013. The Place AIDS programme could mobilize 54 children from the community through district level competition and it was the first time in the history of Champion in Me.

3. Chinnara Chillipili Camp

Intent/Rationale

The chinnara chilipili camp has been conceptualized to reach to children living with HIV to provide them a platform that would teach, explain and speak to them about social protection and how they can/have to protect themselves as they slowly step into adolescence (for instance, tell them about the difference between Good touch & Bad touch), listen to their problems, understand the causes of their discomfort, engage them in creative initiatives/activities which develop in them a sense of leadership, bring to their knowledge practical issues that would come along with adolescence and how to deal with such situations.

A sense of leadership comes with a sense of self-reliance. Chinnara Chilipili seeks to enlighten a sense of self- awareness, reliance and confidence in children for themselves, that usually stands dampened owing to the stigma induced in them by family, peers and society at large.

Image no. 31.

Outcome

25 districts.554 HIV infected / affected children attended the camp. The camps focus on Building leadership and Social Protection of Adolescents infected / affected with HIV.

Exposure and Attention makes a lot of difference!

Krishna, is a seventeen year old boy who attended the Chinnara Chilipili camp. Like most others who attended the camp he came in as a very introvert, timid teenager who was very conscious and uncomfortable to speak. The reason behind this probably could be that he was rarely ever asked to speak about himself. He has been told and treated not like another teen ager but identified as being a "victim" of HIV.

Behind this timid, cold disposure was a person who was angry… very angry with life and the fact that he was living with HIV.

During one of the camp activities he expressed that he does not adhere to the daily routine of taking medicines out of his anger and frustration towards life.

Through the different stages of the two-day camp, Krishna started getting out of the shell. He spoke, he cried, he laughed, he played, he sang and best part was he seemed to be re-kindled with positivity and enthusiasm.

He is now taking up complete medication, is in touch with trainers. He now wishes to participate in such camps more often.

4. Initial assessment of Partner Centres.

Initial assessment was conducted in all partner centers as the first activity of the program to get information about the care center.

This assessment is done based on certain critical criteria extensively covering minute details about the smooth functioning of the Care center. This includes:

- Update of basic information of the Care center- like contact details, registration details, funding agency are put on records
- Information on the population served by the care center in which area or district covered, number of children covered,
- Detail information on resources, infrastructure and regulatory information
- Details of services offered by the center like frequency of visits by medical officers, immunization services available, initiation of ART, no. of children on ART, systems for monitoring personal hygiene, etc.
- Quality of Shelter and care offered by the center
- Psycho social support which includes counselling offered for individuals, groups, family, life skill education, family or community reintegration, family gathering and home visits by staff
- Monitoring the nutritional support offered at the center which includes reviewing the growth monitoring systems, systems to assess the nutrition level

of child, special nutrition supplements, keeping a check on the status of the linkage of the center with existing government schemes

- Education support offered by the center-which includes a check on which form of the schooling the child is attending, orientation of parents and teachers in Public/ Government school, vocational training for children above 14, etc.

5. Partners meet

The first partners meet was organized on 2nd December 2014 at Sneha Care Home. Representatives from 12 partner institutions and KHPT Vihaan Program attended the programme.

6. Self-Assessment facilitation was initiated at the Care Centres to assess the minimum standard at the care center which agreed by the partners.

7. TOT (Collaboration with INSA India)

The program conducted a two days TOT in collaboration with INSA India on Building leadership and Social Protection of Adolescents living with HIV. The participants were staff members KHPT- Vihaan Project, Place AIDS Programme and care centres.

8. Training on Basic Counselling Skills

The programme organized 3 days of training on Basics of Counselling Skills, where 15 counsellors from different care centres attended the training.

This was a skill building training for Counsellors, which dealt with enhancing the counselling quality of a counsellor, basics of counselling skills, enlighten them on the role of a counsellor, role plays on counselling, taking the counsellor to for exposure visits to enhance to capacity to deal with varied situations that might arise during counselling.

An integral part of this training is a Pre-test and Post training Test to develop clarity on the effectiveness of the TOT.


CHAMPION
IN ME 2014

9. Child counselling training (Advance Training on Counselling)

The programme organized 4 days advance training on child counselling.

Counsellors were trained on several issues that are crucial to his/her ability to deal with a child surviving the impacts of HIV. This counselling embraces aspects that are beyond the medicines/ treatment. Training includes:

- understanding the psychology of a child by speaking to a child (who might be orphan and vulnerable), giving him/her that easy space to open up to the counsellor,
- gaining an idea of the level of resilience in a vulnerable, orphan child
- explaining to children how should deal with situations like losing a parent/ family member
- how to explain children the importance of ART and why is it important to adhere to ART in the long run
- speak to children about child rights
- deal with children who different behavioural patterns in a manner that would suit them
- disclosure

10. Visit of Canadian Delegation First lady

The Program coordinated the Visit of Canadian Delegation First lady at Sneha Care Home.

2.8. South to North Project (Rajasthan)

At the request of the National AIDS Control Organisation to Avahan for South to North (S2N) support, KHPT provided technical assistance for the scale up of coverage and the improvement of quality of targeted interventions in the state of Rajasthan. Technical support was provided to the Rajasthan State AIDS Control Society (RSACS), the Rajasthan Technical Support Unit and the State Training Resource Unit (STRC). The activities were completed in March 2014. KHPT was co-located with RSACS and a senior KHPT staff member led this initiative in Rajasthan. The data from 32 existing TI were analysed to identify current status and best performing sites as defined by NACO criteria. Independent consultants evaluated 16 potential learning sites using a tool designed by KHPT and RSACS. 5 of these were identified and transformed to become learning sites, based on the TI population that they covered (FSW, Composite, IDU, migrant), their accessibility to other districts and their interest. KHPT facilitated two exposure visits for RSACS, TSU and NGO partners to Karnataka and Punjab (IDU component). The visits provided an excellent platform for mutual learning and sharing. Four experience sharing and review meetings were facilitated for all TI partners across Rajasthan.Staff from all the non-LS TI were trained at the LS on micro-planning tools and rapid site revalidation. Aravalli conducted an orientation workshop for 32 non-HIV NGOs and mentored them thereafter. Five of these NGOs were successfully contracted by RSACS for TI implementation in the current year. For the first time in many years, RSACS, KHPT and TSU teams made joint visits to almost all the TIs in the state. RSACS released and hosted four documents on their website at the project close out workshop. These documents include rapid site revalidation, data triangulation, process for scale up and sustained quality of interventions and a workshop report for non-TI NGOs.

2.9. Sankalp

Sankalp, a Sanskrit word which means "determination". It is a targeted HIV prevention project focusing on vulnerable and at-risk populations, including men and women in sex work, clients of sex workers, MSM and transgender populations. Sankalp's goal is to reduce the transmission of HIV by promoting the consistent usage of condoms and timely treatment of sexually transmitted infections. It also facilitates the formation of community institutions at the district level.

Funded by:
Bill & Melinda Gates Foundation

Project duration:
December 2003 to July 2014

Geographic Coverage:
Karnataka and Maharashtra

Implementing partner:
A consortium of partners NGOs and CBOs

Key achievements:

During the closing year of the project, Sankalp focused on consolidating the work initiated in Avahan phase I and II in Karnataka.

- Consolidating the impact of the HIV / AIDS programming for FSWs and MSM-T

KHPT has continued to provide post transition support to KSAPS and MSACS and has also monitored the overall progress of the targeted intervention as per NACO requirements. Alongside maintaining focus on reaching out to all those who have newly entered sex work, there has been significant improvement in the programme for MSM and trans genders. 81 percent of new sex workers have been reached with the programme outreach services. The program for MSM-T reflects an improvement in referrals, HIV testing at ICTCs and linkage to treatment.

- Monitoring and Evaluation activities

After completion of the second round of Behaviour Tracking Survey (BTS) and seventh round of the polling booth survey (PBS) a comprehensive report has been developed and shared with KSAPS and the Programme Management Team. The results and learnings of the BTS nad PBS have been systematically disseminated among NGOs and community organizations. Avahan CMIS indicator trend has been analysed on a monthly basis and a structured feedback has been shared with NGOs/CBOs. Numerical estimation of HRGs have been consistently validated and updated by the TIs. KHPT has also shared real time information on 80 per cent of the key populations who migrate to Maharashtra from Karnataka with FHI and Pathfinder. New strategies have been undertaken for migrant programming and it has brought about significant results.

- **Build skills and capacitate communities and NGOs** to ensure HIV prevention programs and vulnerability reduction efforts are sustained post transfer to government/ other partner. The project has prioritised community system strengthening during this reporting period. 16 out of 17 Avahan supported districts have CBOs implementing TI. These CBOs implement 38 TIs in the state. Building capacity of these CBOs including supporting them to mobilise resources has been a major achievement of the project. 14 out of 17 Avahan district CBOs have received funding from UNTF through KHPT to address violence against sex workers. The project has increased the visibility of the sex worker programme and has forged partnership with the judiciary, law enforcement and other women's movement in the state.

- **Support CBOs to organize advocacy events** - The project has supported the CBOs and the networks to organise advocacy events in the state. A two day state level workshop was attended by all CBOs working for FSWs to share their experience, achievements and best practices in community mobilisation. The workshop was also used as a forum to share key issues and concerns with the government of Karnataka with the Minister and few secretaries attending the meeting. The network of MSM CBOs of Karnataka also organised district level campaigns in 18 districts to provide correct information about the article 377 judgement. They also organised a two day state level workshop with community representatives and government officials to share their issues and concerns.

- **Dissemination of learnings and creating a Knowledge base** - KHPT also was successful in creating a knowledge base and disseminating learnings during this reporting period. Several publications and abstracts were presented in international journals and conferences. In addition, the project also hosted several teams from African and Asian countries to learn about the key population programme in the state. This was done through the Bridge project supported by BMGF through FHI 360 to establish learning networks in Africa and Asia. Closer home, staff from KHPT also supported Project ORCHID in north east of India to strengthen their community mobilisation activities including conducting assessment, developing vision and implementation plan, build perspectives and developing governance structures.

- **Supported the state of Rajasthan as part of the South to North knowledge dissemination** - The supported resulted in increasing the number of TIs, increasing coverage of key populations, development of district triangulation reports, increased sharing forums between TI partners and SACs and development of learning sites to build capacity of the TI teams in the state. This process of support is being documented currently.

Committee against Sexual Harassment

"As an organization, we are zero tolerant to any form of sexual harassment!"

Ms. Sunitha BJ,
Director-Capacity Building
Chairperson - GI & CASH (ICC)
KHPT, Bangalore

Karnataka Health Promotion Trust through **the Gender Integration and Committee against Sexual Harassment Internal Complaints Committee** (GI-CASH/ICC) seeks to lay down policies and practices that integrate gender considerations within the organization structure and throughout all programs.

Activities of the committee have ranged from conducting regular sessions on gender sensitive issues, laying a foundation to the policies of the organization to enhance gender integration. The committee serves as an easily accessible forum for employees to place their concerns. Sexual Harassment policies are explained and discussed with newly recruited employees during the induction program.

The New Law – Sexual Harassment of Women at Workplace

The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redress) Act, 2013 was made effective on 23rd April, 2013 (The New Law) by way of publication in the Gazette of India.

The New Law provides the much needed process to redress grievances redress that come from women employees at the work place. The Act ensures a wide scope, to include all women, including domestic help, as the household is her workplace.

The Objective of the New Law

The New Law has been enacted with the objective of providing protection to women against sexual harassment at the workplace and for the prevention and redress of complaints of sexual harassment. Sexual harassment is considered as a violation of the fundamental right of a woman to equality as guaranteed under Articles 14 and 15 of the Constitution of India ("Constitution") and her right to life and to live with dignity as per Article 21 of the Constitution. It is also considered as a violation of a right to practice or to carry out any occupation, trade or business under Article 19(1) (g) of the Constitution, which includes a right to a safe environment free from harassment.

This Act is a big step towards increasing gender equality at work places in India.

KHPT's GI-CASH (ICC):

Accomplishments of the Committee in the last one year:

- The Human Resource Director, KHPT also attended the workshop on understanding the new Sexual Harassment Act - 2013 and thereafter necessary steps have been taken by the committee to formalize the changes in the Sexual Harassment Policy of KHPT.
- The policy to prevent/address sexual harassment has undergone a process of rigorous scrutiny and review. Members of the GI -CASH (ICC) worked to adapt the existing policy framework in sync with the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redress) Act, 2013.
- A workshop was organized for the GI –CASH (ICC) members, where the Head of the Department, Women and Law- Dr. Sarasu Thomas from the National Law School of India University imparted an in-depth understanding on the content and the key elements of this Act.
- **Reconstitution of GI –CASH (ICC):** The GI-CASH (ICC) of KHPT is reconstituted to suit the new Act - 2013 with the following members:

Sl. No.	Names of the Members
1	Ms. Sunitha B.J: as a presiding officer and a Chairperson of the committee
2	Ms. Gursimran Grewal as a management member with social work /sector experience
3	Ms. M.N Hemavathi, senior level employee with social sector experience & also HR representative
4	Ms. Kavitha - Third Party Representative from NGO -Mahila Samakya, Bangalore with rich experience working with women in social sector
5	Mr. Michael Babu Raj, with vast social work / sector experience
6	Mr. Parameshwar Holla, with legal knowledge and social sector experience

Karnataka Health Promotion Trust is a third party member of the Sexual Harassment Inquiry Committee of the National Law School of India University.

- During the year, the GI-CASH, KHPT addressed every concern raised by employees and maintained complete confidentiality on the same.

List of Publications & Abstracts

- Leigh M McClarty, Parinita Bhattacharjee, James F Blanchard, Robert R Lorway, Satyanarayana Ramanaik, Sharmistha Mishra, Shajy Isac, B M Ramesh, Reynold Washington, Stephen Moses, Marissa L Becker. Circumstances, experiences and processes surrounding women's entry into sex work in India. Cult Health Sex 2014 18;16(2):149-63. Epub 2013 Nov 18.

- Gayatri C Jayaraman, Shiv Kumar, Shajy Isac, Prakash Javalkar, Pushpalatha Rama Narayana Gowda, N Raghunathan, Chandra Shekhar Gowda, Parinita Bhattacharjee, Stephen Moses, James F Blanchard. 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 Infect 2013 Dec 17;89(8):635-41. Epub 2013 Sep 17.

- Ravi Prakash, Shajy Isac, Parinita Bhattacharjee, BM Ramesh, Stephen Moses. Assessing the impact of intensive programme utilisation on HIV and sexually transmitted infection prevalence among a high-risk population in urban settings of Karnataka: evidence from three cross-sectional surveys, 2005—12. **The Lancet Respiratory Medicine**, *The Lancet, Volume 381, Page S117, 17 June 2013*

- Souradet Y Shaw, Parinita Bhattacharjee, Shajy Isac, Kathleen N Deering, Banadakoppa M Ramesh, Reynold Washington, Stephen Moses, James F Blanchard. A cross-sectional study of sexually transmitted pathogen prevalence and condom use with commercial and noncommercial sex partners among clients of female sex workers in southern India.. Sex Transm Dis 2013 Jun;40(6):482-9

- Parinita Bhattacharjee, Ravi Prakash, Priya Pillai, Shajy Isac, Mohan Haranahalli, Andrea Blanchard, Maryam Shahmanesh, James Blanchard, Stephen Moses. 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:S46-54.

- Faran Emmanuel, Shajy Isac, James F Blanchard. Using geographical mapping of key vulnerable populations to control the spread of HIV epidemics. Expert Rev Anti Infect Ther 2013 May;11(5):451-3.

- 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.

- Blanchard AK, Mohan HL, Shahmanesh M, Prakash R, Isac S, Ramesh BM, Bhattacharjee P, Gurnani V, Moses S, Blanchard JF. Community mobilization, empowerment and HIV prevention among female sex workers in south India. BMC Public Health 2013; 13:234.

- Lazarus L, Reza-Paul S, Pasha A, Jairam S, Ur Rahman SH, O'Neil J, Lorway R. **Exploring the role of community-based peer support in improving access to care and antiretroviral treatment for sex workers in Mysore, India.** J HIV / AIDS Soc Serv 2012; 11:152-68.

- Mahapatra B, Lowndes CM, Mohanty SK, Gurav K, Ramesh BM, Moses S, Washington R, Alary M. Factors associated with risky sexual practices among female sex workers in Karnataka, India. PloS One 2013; 8(4):e62167.

- 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.

- Mony PK, Krishnamurthy J, Thomas A, Sankar K, Ramesh BM, Moses S, Blanchard J, Avery L. Availability and distribution of emergency obstetric care services in northern Karnataka state, south India: access and equity considerations. PloS One 2013; 8(5):e64126.

- 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.

- McClarty LM, Bhattacharjee P, Blanchard JF, Lorway RR, Ramanaik S, Mishra S, Isac S, Ramesh BM, Washington R, Moses S, Becker ML. Circumstances, experiences, and processes surrounding women's entry into sex work in India. Cult Health Sex 2014; 16:149-63.

- Mishra S, Mountain E, Pickles M, Vickerman P, Shastri S, Gilks C, Dhingra NK, Washington R, Becker ML, Blanchard JF, Alary M, Boily M-C, for the Strategic Epi-ART in India Modelling Team (Moses S, Halli S, Rewari BB, Bakkali T, Chandra N, Ramesh BM). Exploring the population-level impact of antiretroviral treatment: the influence of baseline intervention context. AIDS 2014; 28(Suppl 1):S61–72.

- Gurav K, Bradley J, Gowda GC, Alary M. Perspectives on condom breakage: a qualitative study of female sex workers in Bangalore, India. Cult Health Sex 2014 [Epub ahead of print].

Financial Reports

R. Venkatakrishnan & Associates
Chartered Accountants

INDEPENDENT AUDITORS' 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 31st March 2014 and the Income and 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 the preparation of these financial statements that give a true and fair view of the financial position and financial performance of the Trust in accordance with accounting principles generally accepted in India. This responsibility includes the design, implementation and maintenance of internal control 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. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. 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.

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Telefax : +91 80 2341 8753 E-mail : bangalore@rvkassociates.com website : http://www.rvkassociates.com
Head Office : Chennai **Branch : Devanahalli, Hyderabad, Salem**

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, 2014; and

(ii) in the case of the Income and Expenditure Account, the excess of income over expenditure for the year ended on that date.

Place: Bangalore
Date:

For R. Venkatakrishnan and Associates
Chartered Accountants
Firm No.008572S

24/9/2014

R. Mohan
Partner
Membership No.203911

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, 2014 - Consolidated

Particulars	Schedule	31st March, 2014 (Rupees)	31st March, 2013 (Rupees)
I Sources of Funds			
1 Reserves			
Corpus fund	1	10,000	10,000
General Reserve	2	39,125,824	35,083,279
Grant Received in Advance	3	69,534,526	48,089,941
Total		108,670,350	83,183,220
II Application of Funds			
1 Current Assets, Loans and Advances			
Cash and Bank Balances	4	99,174,913	72,758,666
Loans and advances	5	12,754,376	15,358,840
Total		111,929,289	88,117,506
2 Less : Current liabilities and provisions			
Current Liabilities	6	2,660,775	4,421,818
Provisions	7	598,164	512,468
Total		3,258,939	4,934,286
Net current assets		108,670,350	83,183,220
Total		108,670,350	83,183,220

For Karnataka Health Promotion Trust

Dr. Reynold Washington
Managing Trustee

Nanjundappa G.M
Director Finance

Place: Bangalore
Date : 24-Sep-2014

As per our audit report of even date attached
For R. Venkatakrishnan & Associates
Chartered Accountants
Firm No. 0085725

24/9/2014.

R. Mohan
Partner
Membership No. 203911

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

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, 2014 (Rupees)	For the year ended 31st March, 2013 (Rupees)
Income			
Grants Received - Utilized	3	354,827,006	311,414,895
Interest Income	8	4,330,947	4,171,283
Donations Others		76,214	63,749
Sale of Assets		254,198	3,480,935
Exchange Difference & Misc Income		3,319	1,957,183
Total		359,491,683	321,088,045
Expenditure			
Programme Expenses	9		
-Grants to NGO's		102,339,772	84,348,047
-Grants to NGO's in Kind		199,381	-
-Other Programme Expenses		88,210,584	92,249,442
-Training and Capacity Building Expenses		13,622,230	10,609,296
		-	-
Personnel Expenses	10	90,767,061	77,925,920
Administrative and other expenses	11	60,310,110	49,884,810
Total		355,449,139	315,017,515
Excess of Income over Expenditure transferred to General Reserve		4,042,545	6,070,530

For Karnataka Health Promotion Trust

Dr. Reynold Washington
Managing Trustee

Nanjundappa G.M
Director Finance

Place: Bangalore
Date : 24-Sep-2014

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

24/9/2014

R. Mohan
Partner
Membership No. 203911

KARNATAKA HEALTH PROMOTION TRUST (KHPT)

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

	As at 31st March, 2014 (Rupees)	As at 31st March, 2013 (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	35,083,279	29,012,749
Add: Transferred from Income & Expenditure A/c	4,042,545	6,070,530
	39,125,824	**35,083,279**
Schedule 3: Grant Received in Advance		
Opening balance	48,089,941	36,252,621
Grants Received during the year		
University of Manitoba	202,472,119	155,167,106
PHFI	-	4,082,332
PSI Segmentation Study	-	5,869,036
LSHTM	5,920,283	11,492,385
CGHDDH-Boston University	-	367,725
ICRW	-	551,197
CBCI Society for Medical Education	4,059,479	-
Abt Associates Inc	17,237,210	-
MAC AIDS FUND	6,224,091	-
Individual Donation-Gerry	313,000	-
Geneva Foundation for Medical Research (GFMER)	100,290	-
India Health Action Trust	6,244,179	-
Stitching Aids Funds-Netherlands Staff	264,163	-
Karnataka State Aids Prevention Society - KSAPS	18,299,916	20,777,949
The Global Fund to Fight AIDS, Tuberculosis, and Mala	15,404,881	81,922,704
ICMR	-	4,642,158
KHSDRP	-	568,231
NRHM	-	1,528,846
GOK-GSPP	1,354,000	160,330
WCD-Sahala	376,373	1,044,403
UN WOMEN	43,720,784	-
WCD-Special Care Programme	533,610	-
Maharashtra State Aids Control Society(MSACS)	37,282,515	16,019,698
James N Jacob- Project House Exepenses	-	969,048
India HIV/AIDS Alliance	31,702,900	-
	439,599,735	**361,415,768**
Less:		
Refund of Grant Funds		
MAC AIDS FUND	3,316,826	-
LSHTM- Sudhashree	195,213	-
KSAPS-Sampoorna-LWS	4,540,019	-
ICMR-Assessment of Sexual & Reproductive Health	68,718	-
MSACS-LWS	7,114,108	-
Exchange Fluctuation Income transferred	3,319	1,910,931
Grant Utilized transferred to Income & Expenditure Account	354,827,006	311,414,895
	370,065,208	**313,325,827**
Grant Received in Advance	**69,534,526**	**48,089,941**

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, 2014 (Rupees)	As at 31st March, 2013 (Rupees)
Schedules forming part of the accounts - Consolidated		
Schedule 4: Cash and bank balances		
Cash in Hand	381,471	334,312
Balance with Schedule Banks		
- in savings accounts	43,793,442	72,424,354
- in deposit accounts	55,000,000	-
	99,174,913	**72,758,666**
Schedule 5: Loans and advances		
Advances recoverable in cash or in kind or for value to be received	7,735,465	10,075,534
TDS receivable	1,784,571	1,512,465
Deposits	3,234,340	3,770,840
	12,754,376	**15,358,840**
Schedule 6 : Current liabilities		
TDS payable	1,209,511	937,982
Sundry creditors	907,252	2,923,410
Other liabilities	544,011	560,425
	2,660,774	**4,421,817**
Schedule 7 : Provisions		
Accruals	598,164	512,468
	598,164	**512,468**

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, 2014 (Rupees)	As at 31st March, 2013 (Rupees)
Schedules forming part of the accounts - Consolidated		
Schedule 8: Interest Income		
Savings Bank Accounts	2,148,859	1,804,471
Fixed Deposits	2,145,536	2,366,812
Income Tax Department	36,552	-
	4,330,947	**4,171,283**
Schedule 9 : Programme Expenses		
-Grants to NGO's	102,339,772	84,348,047
-Grants to NGO's in Kind	199,381	-
-Other Programme Expenses	88,210,584	92,249,442
-Training and Capacity Building Expenses	13,622,230	10,609,296
	204,371,968	**187,206,785**
Schedule 10 : Personnel Expenses		
Salaries	37,591,726	40,884,212
PF Employers' Share	3,355,619	4,682,181
Leave Encashment	23,069	21,050
Leave Travel Allowance	2,259,437	2,272,319
Consultancy Charges	43,493,914	27,334,846
Recruitment Expenses	150,064	182,054
Gratuity	1,221,570	345,040
Insurance-Staff	2,671,662	2,163,891
Ex-Gratia	-	40,327
	90,767,061	**77,925,920**

KARNATAKA HEALTH PROMOTION TRUST BANGALORE INDIA

B. VENKATAKRISHNAN & ASSOCIATES CHARTERED ACCOUNTANTS BANGALORE

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, 2014 (Rupees)	As at 31st March, 2013 (Rupees)
Schedule 11 : Administrative and other expenses		
Fixed Assets		
Computers	2,155,438	279,720
Furniture & Equipments	871,136	544,235
Communications		
Courier Charges	611,160	896,741
Data Card Expenses	1,162,073	1,092,906
Email/internet & Wireless	-	617
Internet Charges	390,362	366,928
Mobile Charges	905,321	849,804
Postage & Telegrams	1,081	1,540
Telephone Charges	285,845	186,871
Office Running Expenses		
Advertisement Expenses	-	16,527
AMC for Equipments & Others	661,291	558,181
Bank Charges	60,271	82,736
Books & Periodicals	110,814	1,030
Computer Running Expenses	323,756	387,695
Electricity/Water /Maintenance Charges	959,503	1,325,150
Insurance -Assets	36,501	95,560
Office Expenses	953,041	641,036
Office Repairs and Maintenance	184,994	941,562
Printing & Stationery	3,216,631	1,568,894
Rent-Office	4,829,821	5,739,963
Rent - Others	1,785,460	1,392,706
Security Service Charges	310,116	268,992
Software Expenses	1,775,494	1,150,668
Subscription & Membership Fee	10,000	-
Staff Welfare-Tea/coffee/meal	195,929	174,182
Project House Expenses	64,148	115,934
Brokerage Charges	-	58,000
Other Expenses		
Documentation & Research	116,349	-
Meeting Expenses	4,476,619	2,608,202
Interest Paid-Income Tax	7,606	1,782
Travel Expenses-Staff & Consultants		
Local Conveyance	156,208	105,239
Travel Expenses-International	7,824,527	7,695,655
Travel Expenses-National-Accommodation	5,346,975	3,184,288
Travel Expenses-National-Air tickets	9,121,848	6,086,827
Travel Expenses-National-Others	3,771,868	5,145,811
Travel Expenses-National-Perdiem	3,350,200	2,710,820
Travel Expenses-National-Train/Bus	1,744,482	1,514,012
Consultancy Expenses	186,224	190,621
Vehicle Repair & Maintenance		
Vehicle-Insurance	118,330	52,830
Vehicle-Repair & Maintenance	1,901,159	1,517,985
Professional Charges-Audit Fees		
Audit Fees-Other Services	8,988	41,015
Audit Fees-FY-2012-13	-	259,738
Audit Fees-FY-2013-14	318,541	-
Professional Charges		
Professional Fees	-	31,806
	60,310,110	**49,884,810**

Karnataka Health Promotion Trust
IT Park, 5th Floor, # 1-4, Rajajinagar Industrial Area,
Behind KSSIDC Administrative Office, Bangalore- 560044