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hiv prevention in vulnerable indian states: lessons from the *chayan* project

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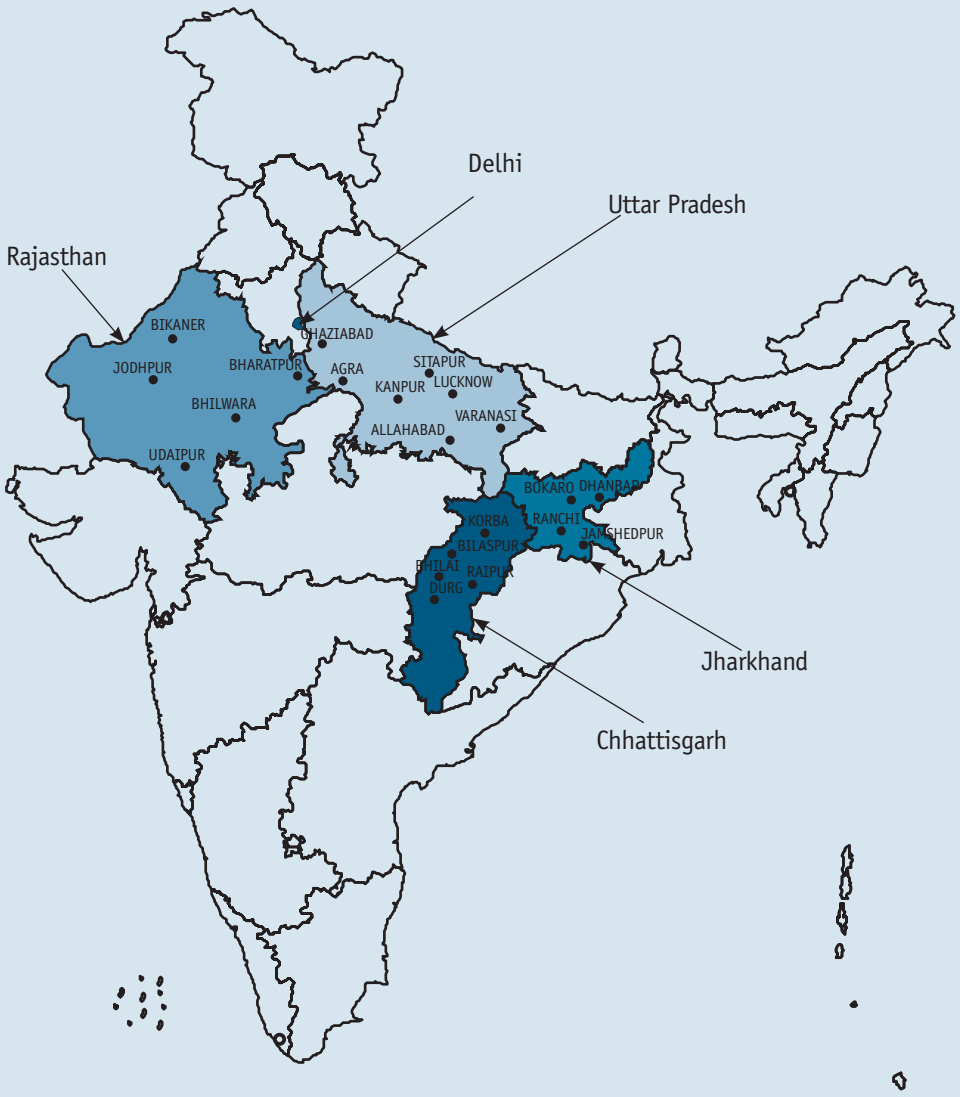
HIV Prevention Interventions in 22 *Chayan* Cities



Peer Educators:	
Chhattisgarh	= 2612
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Jharkhand	= 1204
Rajasthan	= 3573
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HIV Prevention in Vulnerable Indian States: Lessons from the *Chayan* Project

Summary

CARE seeks a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. With over sixty years experience in assisting communities to address development challenges and improve their livelihoods, CARE is uniquely positioned to contribute to the fight against HIV epidemic. Currently, CARE has about 126 projects in 39 countries in Africa, Asia, Latin America and the Caribbean, and Eastern Europe.

India is home to two-thirds of the 8.3 million people living with HIV in Asia, posing a serious public health challenge. Low human development indices and poverty intensify this challenge manifold. To respond to HIV/AIDS epidemic, Government of India, launched the National AIDS Control Programme (NACP) in 1987. Currently National AIDS Control Organisation (NACO) is in the process of finalizing the implementation plan of NACP III (2007-2011), with the objective of consolidating and building on the gains achieved during the last two phases of the program. The third phase of NACP aims to prevent new infections among high risk groups through saturating coverage of targeted interventions and scale up of interventions in general populations.

Being a large country, NACO has divided India[1] into "high", "moderate" and "low" HIV prevalence states; the latter more recently are called as "vulnerable states" with inadequate data on prevalence levels, to allow for policy and operational focus. Eight states - Uttar Pradesh (UP), Rajasthan (RA), Chhattisgarh (CG), Jharkhand (JH), Bihar (BI), Madhya Pradesh (MP), Uttaranchal (UA) and Orissa (OR)) are especially vulnerable. State AIDS Control Societies (SACS) in these vulnerable states were relatively new and the capacity to mount a strong program was weaker due to inadequate surveillance systems, paucity of skilled professionals and poor health care infrastructure. In addition, unfavorable socio-political-legal environment, high levels of migration, stigmatization of certain population groups further increased their vulnerabilities, but were seldom woven into program design and implementation.

In response to the emerging scenario in these states, CARE India, with financial and technical support from United States Agency for International Development (USAID), expanded its existing child health and nutrition program to include HIV prevention interventions specific to the epidemiological trends and structural needs in the states. During 2002-2003, CARE India designed and launched HIV prevention interventions, in the states of Uttar Pradesh, Jharkhand, Chhattisgarh, Rajasthan and Delhi with the objective of halting the transmission in these states. While there was inadequate infrastructure in these states to

[1] The recent classification by NACO has categorized districts into A, B, C and D based on the available data on prevalence rates. Highest prevalent Categories A and B districts were identified from the "moderate" and "low prevalence" states as well

detect the epidemic early and respond effectively, CARE's on-going Reproductive, Child Health, Nutrition and HIV/AIDS (RACHNA[2]) program had established a strong program platform in terms of institutional relationships with the Government programs and civil society organizations in these low prevalence states. This provided *Chayan* a head start in responding to HIV/AIDS epidemic and reaching the most marginalized and vulnerable populations. *Chayan*'s goal is to reduce sexual transmission of HIV, through risk reduction among select high-risk behavior groups[3] (HRBG) and vulnerable youth. It is operational in 22 cities in four of the nine RACHNA states – Uttar Pradesh (UP), Rajasthan (RA), Chhattisgarh (CG) and Jharkhand (JH), as well as selected areas in Delhi.

This document highlights the results and associated processes from *Chayan*'s implementation experience under the RACHNA program. The programmatic framework, designed for low-prevalence contexts in India, draws on standard targeted intervention approaches but is grounded in community-based methods unique to local contexts. Evaluation findings reveal significant changes in key indicators including condom use and treatment seeking behavior for Sexually Transmitted Infections.

The findings from the Behavior Surveillance Survey (BSS) conducted by CARE in 2006 and the external review indicate encouraging results as compared to BSS in 2003. Data from BSS shows significant improvements in knowledge and practices relating to safer sex and treatment-seeking among the target groups, despite the short implementation period of three years. In India's poorest, most populated and vulnerable states, *Chayan* has succeeded in creating a cadre of skilled implementers and partners in 22 cities. Community level planning, technical inputs, coaching and mentoring capacities at large-scale have allowed CARE to obtain substantial reach. The *Chayan* model is both precise in terms of its objectives and measures and unconventional in terms of creative actions and innovations necessary to manage the variations of vulnerable populations at a vast scale.

Following are some of the major contributions and strengths of *Chayan*:

- Creating and nurturing a resource pool of qualified and committed professionals who have technical and operational competence in managing HIV prevention interventions, especially in low-prevalence settings
- Thirty-three local NGO partners, in 22 cities to implement targeted interventions for HIV prevention.
- Establishing "demonstration sites" with composite interventions approach among high-risk groups to reach all possible target groups in a geographic area e.g., truckers, migrants, female sex workers (FSWs), males having sex with males (MSM), injecting drug users (IDUs), and transgender.

[2] RACHNA, is an umbrella program of CARE India supporting Integrated Child Development Services (ICDS), Reproductive and Child Health (RCH) and National Aids Control Program (NACP) programs in the areas of Maternal Health and Nutrition, Child Health: Immunization and Newborn Care, Infant and Young Child Nutrition, Birth Spacing and HIV Prevention. Currently, RACHNA program is implemented in 78 districts across nine states (UP, JH, CG, BI, RA, AP, WB, OR and MP). The current phase of RACHNA began in October 2001 and will end in September 2006. The Reproductive health interventions under RACHNA are implemented in rural and urban areas of 29 districts in the same four (excludes Delhi) states.

[3] HIV prevention interventions in urban areas target unmarried youth in age group of 15-24 years (in school and out of school) and high risk behavior groups including female sex workers, migrant workers and truckers and their associates

- Developing and using a number of tools, processes and materials that could be appropriately adapted for large scale program implementation. Some of these include:
  - Guidelines for local Needs Assessment and Stakeholders Analysis (NASHA), which help implementing NGOs develop locally relevant micro-plans
  - Approaches to defining denominators, updating denominators and setting up tracking systems to maximize the reach and coverage.
  - Operational guidelines, training and communication materials for working with youth. These include life skills development, peer education, youth resource centers (YRC) and building an enabling environment
  - Establishing referral networks with existing STI treatment facilities and focusing on ensuring treatment outcomes.
  - Evolving approaches for mobilization of community and multi-stakeholder support for creating enabling environment for HIV prevention efforts

While SACS have been very responsive to work with *Chayan* in all the states, less than optimal infrastructure and institutional capacities of SACS and their partners have been a constraint, especially in the newly constituted states of Jharkhand and Chhattisgarh. Systematic and proactive engagement with SACS and education departments at the state level facilitated ownership and commitment of these key systems to improve the HIV prevention programs. *Chayan*'s support to strengthening SACS and building NGOs capacity to operationalize HIV interventions provided a boost for the efforts of NACP in these states.

Chayan is uniquely positioned to inform HIV prevention efforts to reach scale and achieve quality of implementation, especially in the low prevalence contexts. The focus on prevention at a large-scale targeting the most vulnerable groups has the potential to turn the HIV epidemic around, preventing AIDS from having a more severe impact on the Indian population.

Background

CARE is an international relief and development organization, with substantial experience of implementing HIV prevention and control programs across the world. CARE has about 126 projects in 39 countries in Africa, Asia, Latin America and the Caribbean, and Eastern Europe. With over sixty years of experience of assisting communities to address development challenges and improve their livelihoods, CARE is uniquely positioned to contribute to the fight against HIV epidemic.

CARE began its work in India in 1950. Currently, CARE in India works in the sectors of health, nutrition, and HIV prevention, girl's education, small economic activity development, urban development, tribal empowerment, emergency preparedness and relief and rehabilitation. CARE has been a close ally and a partner of the Ministry of Women and Child Development (MWCD) and Ministry of Health and Family Welfare (MoHFW). CARE's interventions in HIV/AIDS in India are guided by the national program guidelines laid out by National AIDS Control Organisation (NACO) and complement the priorities addressed by National AIDS Control Programme (NACP).

Current Scenario of HIV Epidemic in India

HIV presents a significant public health challenge for India – home to two-thirds of the 8.3 million people living with HIV in Asia live in India, with an adult prevalence rate of 0.9 percent (range 0.5 percent-1.5 percent) and an estimated 5.2 million[4] HIV positive people in the age group of 15-49 years. India is on the verge of reaching, what many experts believe to be the "tipping point" of a country's HIV/AIDS epidemic. The country is divided into “high”, “moderate” and “low” prevalence areas[5]; the latter are called as “vulnerable states” with unknown prevalence. Eight states - Uttar Pradesh (UP), Rajasthan (RA), Chhattisgarh (CG), Jharkhand (JH), Bihar (BI), Madhya Pradesh (MP), Uttaranchal (UA) and Orissa (OR)) are especially vulnerable, as reflected by low human development indicators, high migration levels, poor health infrastructure and limited access to health services.

Surveillance data from different states also indicate that although HIV/AIDS is still largely concentrated among high-risk populations[6], the epidemic is slowly moving beyond these groups into the general population and from urban to rural. Overall, most HIV infections (more than 80 percent of reported AIDS cases) are due to unprotected heterosexual intercourse and a significant proportion of them are in women.[7]

The trajectory of the AIDS epidemic clearly demonstrates a shift towards women and young people, with 25 percent of all HIV infections occurring in women. Like women, youth too are increasingly affected by HIV/AIDS. The future size of India’s HIV epidemic will depend particularly on the effectiveness of programs for sex workers and their clients, males having sex with males (and their sexual partners) and injecting drug users (and their other partners).[8] On a positive note, HIV prevalence rates have declined in four of the high-prevalence states[9] where sustained prevention efforts began since early 1990s.[10]

National Response to HIV/AIDS in India

To respond to HIV/AIDS epidemic, Government of India (GoI) launched the National AIDS Control Programme in 1987. The first phase of NACP focused on increasing community awareness, strengthening management capacity for controlling HIV epidemic and building surveillance and clinical management capacity. The NACP II shifted its focus from awareness to changing behaviors, decentralization of service delivery to the states and structured and evidenced based annual review and management reforms. Interventions targeting high-risk behavior groups were expanded and inter-sectoral linkages were established with development partners. Despite focused efforts and progress made during NACP II, a number of lessons were drawn with regard to geographical focus, target group

[4] UNAIDS 2006 Report on Global AIDS Epidemic
[5] In a more recent categorization, NACO has classified districts into category ‘A’, ‘B’, ‘C’ and ‘D’ based on the available data on HIV prevalence. Among the total 611 districts across the country, 163 belong to category ‘A’ and 59 to category ‘B’ indicating the highest prevalence
[6] Truckers, migrants, female sex workers (FSWs), males having sex with males (MSM), injecting drug users (IDUs), and transgender.
[7] NACO 2005
[8] Kang et al., 2005 (in UNAIDS Global Report 2006)
[9] Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur, Nagaland
[10] UNAIDS 2006 Report on Global AIDS Epidemic

and implementation approach, given the changing face of the HIV epidemic. This led to designing and implementation of third phase of NACP (2007 to 2011) with the objective to consolidate and build on the gains achieved during the last two phases. The third phase of NACP aims to halt the epidemic in India over the next 5 years through integration of prevention and care, support and treatment programs. The main objective is to prevent new infections among high-risk groups through saturation of coverage with targeted interventions and scale up of interventions among general populations.

In summary, there is tremendous support and momentum within the GoI to control the HIV epidemic in India. Policies and programs have been designed, refined and modified over a period of time to reflect this ultimate goal. But, there is considerable unfinished work in the states to fully translate this commitment into implementation. CARE's experiences suggest that considerable gaps and challenges exist if response to HIV in the vulnerable, low prevalence states has to be effective, such as:

- **Limited understanding and focus on evidence-based response for reduction of HIV transmission:** State AIDS Control Societies (SACS) in some of these highly vulnerable states are inadequately equipped to use available data and to proactively build up evidence based response; i.e. determine and implement approaches that are most likely to reduce transmission of HIV/AIDS. At the same time, there is growing interest among civil society, academic/research agencies and private sector to contribute in building up the States' response to HIV/AIDS.

- **Inadequate reach of Targeted Interventions (TI) among high risk behavior groups (HRBG)**: In many cities with high proportions of high-risk populations the TIs have not yet reached saturation, while in some others, where the TIs are being implemented, all the high risk groups are not yet covered. Vertical TI approaches focusing only on single high-risk group often limit the ability to curtail the spread of infection. There is a need for all TIs to analyze the transmission dynamics in each of the contexts and design interventions.

- **Inadequate infrastructure, staffing and supplies**, especially in the northern states limit the ability of the SACS to provide basic operational conditions for a full-fledged HIV/AIDS program. The capacity to mount a strong program is inadequate in some of the highly vulnerable states due to large population, migration, the weak surveillance systems and poor health care infrastructure, reach of services, staffing, training systems and drug supplies.

- **Limited engagement of sectors other than Health**: HIV is primarily seen as the domain of NACO/Department of Health and Family Welfare (DHFW) alone. Although there are important roles expected from Departments of Education, Women and Child Development, Panchayat[11] and Rural Development and others, institutionalized mechanisms for supporting their roles in HIV prevention interventions remain inadequate. This is a critical factor to be addressed, as the NACP III attempts to scale-up and build a genuine multi-sectoral response to the epidemic.

[11] Under the Constitution (Article 243B), panchayat is an institution of self-governance for rural areas.

- **Unavailability of skilled professionals to manage HIV/AIDS interventions**: Most highly vulnerable states find it difficult to recruit professional staff with skills, experience and sensitivities required for HIV prevention work. Also, there is significant turnover in the key leadership and technical staff resulting in limited continuity and variable performance across states.

- **Feminization of HIV/AIDS**: Although there is growing recognition of the "feminization" of the epidemic, there are very few operational models available to demonstrate how to effectively integrate gender and equity dimensions in the HIV prevention and management programs.

In view of the broadening and deepening of the epidemic, there is a need for greater focus on youth, women and children. HIV/ AIDS awareness interventions targeting adolescents and youth through schools and other approaches need to be strengthened. All these gaps were analyzed and considered by CARE while designing a response to reducing transmission of HIV epidemic in vulnerable states of India.

CARE's Commitment to Reduce Transmission of HIV/AIDS: The Urban *Chayan* Project

CARE has been implementing a child health and nutrition project called the Integrated Nutrition and Health Project (INHP) in India since 1996 across nine[12] states. During the second five-year phase of INHP (2002-2006), additional support from USAID India through *Chayan*[13] Project enabled CARE to expand its health interventions package to include Reproductive Health and HIV prevention. These were implemented in a subset of four states of Uttar Pradesh (UP), Rajasthan (RA), Jharkhand (JH) and Chhattisgarh (CG) and selected slums of Delhi.

Together the INHP and *Chayan* projects form the program titled, Reproductive and Child Health and Nutrition and HIV/AIDS (RACHNA[14]). *Chayan* focuses on establishing replicable operational models for targeted interventions among high-risk groups in these vulnerable states. The project also works with youth (15-24 years) with interventions to reduce their vulnerability. It works with men and women of reproductive age (15-45 years) in rural areas for improving awareness, condom promotion for dual protection and increasing access to Sexually Transmitted Infections (STI)/Reproductive Tract Infections (RTI) services through linkages with the national programs of Reproductive and Child Health (RCH) and Integrated Child Development Scheme (ICDS). With the launch of *Chayan* Project in 2002, CARE India became one of the early entrants in HIV prevention work in the highly vulnerable states.

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[12] Nine states where child survival interventions are implemented are: Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. Three districts of Bihar was added in FY 04 during the DAP Amendment process for INHP II.

[13] The term *Chayan* means "choices, or selection" in Hindi.

[14] RACHNA, is an umbrella program of CARE India supporting ICDS, RCH and NACP programs in the areas of Maternal Health and Nutrition, Child Health: Immunization and Newborn Care, Infant and Young Child Nutrition, Birth Spacing and HIV Prevention. Currently, RACHNA program is implemented in 78 districts across nine states (UP, JH, CG, BI, RA, AP, WB, OR and MP). The current phase of RACHNA began in October 2001 and will end in September 2006. The Reproductive health interventions under RACHNA are implemented in rural and urban areas of 29 districts in the same four (excludes Delhi) states.

This document intends to capture the results and associated processes of HIV prevention interventions among female sex workers, migrant workers, truckers and their associates and youth implemented in 22 cities. It also introduces a programmatic framework intended for low-prevalence contexts in India, which draws on standard targeted intervention approaches while being grounded in comprehensive community-based methods.

Programmatic Context for HIV Prevention in Vulnerable States

The large size and population density coupled with socio-economic vulnerabilities leading to extreme poverty, illiteracy, and migration makes the low prevalence states additionally vulnerable. While HIV estimates in urban settings have remained almost steady, there has been a three-fold increase in rural settings since 2001.[15] Indeed, a significant percentage of out migration happens from these states to major cities as well to other states. Many of these migrants and transport workers travel to big cities like Mumbai, where HIV prevalence is significantly higher, while the HIV/AIDS epidemic is still concentrated among high risk behavior groups, CARE's on the ground analysis reveals that these groups are integrated into the social fabric of the poor and therefore are harder to reach.

Since HIV/AIDS prevention interventions have focused on high prevalence states, the SACS and NGOs in the northern states have, until recently, had limited capacities to lead the necessary course of action.

CARE's rationale for working on HIV/AIDS prevention in low prevalence states is three fold - surveillance data showing incremental increases in prevalence, a need to keep low-prevalence states low, and the opportunity to build on CARE's established health and nutrition platform on which to deliver discrete and integrated HIV/AIDS interventions.

> It is important to note that the 'low prevalence' Indian states account for a major portion of the population of India, and considerably more people live in the 'low prevalence' states than in the 'high prevalence' states. Thus, an unchecked HIV/AIDS epidemic in these states would be particularly devastating.
>
> - RACHNA Final Evaluation Report, 2006

From Commitment to Action: The Implementation Approach of *Chayan*

Chayan selected three groups at highest risk for HIV infection representing the core (female sex workers) and bridge populations (migrants, truckers and their associates). In order to prevent vulnerability leading to risk, *Chayan* also included unmarried youth from age 15 to 24 years.

[15] HIV/AIDS Epidemiological Surveillance & Estimation report for the year of 2005, NACO, April 2006.

"First it's important to reach out to women about information on HIV and how it can be prevented. They will bring about change. Men are free birds, but women can do miracles once they resolve to."

– Female Sex Workers, Lucknow

Chayan's implementation model had a dual focus - demonstrating operational models for reducing transmission of HIV/AIDS and simultaneously facilitating scale up of interventions through SACS and other partners. This was done through establishment of **demonstration sites** to provide operational models for prevention of HIV targeting high-risk behavior groups and youth. The learnings from demonstration sites were widely shared to inform the rest of the program areas. CARE worked closely with the SACS and its partners to scale up the targeted interventions and integrate the lessons from *Chayan* to saturate the reach to all target groups. By working with a large number of NGOs and other civil society organizations, *Chayan* enhanced their capacities to support the national program for HIV prevention.

Approaches for Reaching and Engaging the High-risk Behavior Groups

In working with the high-risk groups, the major focus of *Chayan* in '**demonstration areas'** was to saturate reach to all target groups in the identified locations informed by an analysis of transmission dynamics. Program inputs in 'demonstration sites' included:

- Mapping and tracking of the target groups
- Creation and expansion of outlets with condoms
- Establishing STI referral networks
- Multi-channel behavior change communication (BCC)
- Inter-personal communication through peer educators
- Active involvement of community stakeholders for creating an enabling environment.

Some of the highlights of the implementation approach were a strong community mobilization and efficient tracking systems along with regular updation of denominators with an understanding of transmission dynamics. Other activities included establishment of outlets for free and/or socially marketed condoms and referral links to qualified service providers in public and private sector for treatment of STI/RTI.

Features of a Demonstration Site

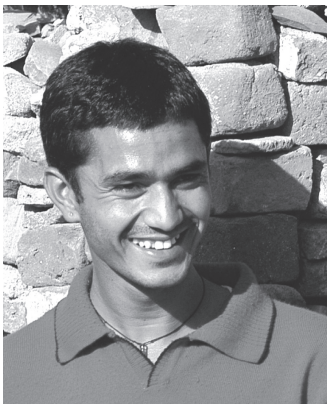
- Presence of NGO partners
- Active community stakeholders
- Functional peer educators
- Multi-channel Behavior Change Communication
- Linkages with traditional and non-traditional Condom outlets
- Established referral networks for RTI/STI prevention and management

Approaches for Reaching and Engaging the Youth

For youth interventions, a subset of urban Integrated Child Development Scheme (ICDS) catchment areas, which comprised a cluster of *Anganwadi* Centers (AWCs), was identified for demonstration work. Schools and colleges attended by the youth from the ICDS catchment area were selected for in-school interventions. Each demonstration site had an approximate population of 15,000–20,000. The educational institutions being targeted were mainly the highs-schools, inter-colleges and degree colleges. The rationale for selecting ICDS areas for programming was to optimize on the impact of ongoing INHP and family planning interventions. However, four of the 22 cities - Korba (CG), Udaipur (RA), Varanasi (UP) and Delhi – did not have the child survival and family planning interventions of RACHNA. In all the cities, the programming universe constitutes slums (*bastis)* or resettlement colonies of people belonging to low socio-economic status.

Promoting responsible sexual behavior among youth population was the cornerstone of the *Chayan* program. Typically the program inputs in demonstration areas were:

- Initial rapport-building and social sanction activities
- Inter-personal communication through peer education to promote behavior change
- Life-skills education for empowering youth to make choices and decisions to lead healthy lives
- Establishing youth resource centers (YRCs) to allow young people to have access to information on health and other life-skills. These YRCs were also intended to act as recreational facilities where vocational training can be imparted
- Creating community stakeholder groups to support reproductive health interventions and understand their vulnerabilities



"I want a companion in my wife. Not a slave. I will challenge my family if they do not accept my thinking. We cannot treat women as unequals anymore."

– Youth, Kawakhera

Critical to the above approaches in demonstration areas, were the roles of local NGO partners and their familiarity with local communities. NGOs were capacitated to map health service providers for STIs for establishing referral networks, select and train peer educators from the target communities and follow up and track STI cases to ensure compliance to treatment. NGOs also conducted communication activities and mobilized communities to address issues of gender inequity, stigma, discrimination and create an enabling environment for HIV prevention work. The program innovated with strategies such as *'maa beti sammelan'* (mother daughter meetings), picnics for young women and men, gender sensitization for truckers and migrants that have been useful in challenging stereotypes which curb discussions and interventions on sexual and reproductive health. NGOs also coordinated with social marketing agencies, government health facilities to establish and maintain adequate condom outlets in the demonstration sites. Monitoring the project through supervision and review meetings of peers and outreach workers and coordination with SACS supported NGOs for complementarity and cross-learning.

Table 9.1: **Overview of HIV prevention components of *Chayan* Project**

	High Risk Behavior Groups	Youth
Target Group	Female sex workers[16], migrants[17], and truckers and their associates[18]	Unmarried women and men between 15 to 24 years of age
Geographic Focus	22 cities across four states and Delhi, covering a radius of 20 kilometers around each city	ICDS catchment areas of 22 selected cities.
Interventions	• Prevention and management of RTI/STI • Correct and consistent condom use	• Life skills education to promote responsible sexual behavior • Awareness on HIV/AIDS
Strategies	***Establish non conventional condom outlets to ensure access***	***Youth Resource Centers*** (YRC) provide space for out-of-school youth to receive life-skills messages
	Establish referral networks and tracking systems to ensure treatment outcomes for STIs	***Sensitize health service providers on youth SRH and establish links with Youth Friendly Services***
	• ***Geographic and Social analysis*** (mapping, needs assessment, stakeholder analysis and ongoing reflective practice sessions on transmission dynamics) • ***Behavior change communication interventions*** through ***peer education*** across the range of target groups in a given project site based on analysis • ***Community Stakeholder Groups*** to obtain social sanction, disseminating behavior change messages	

Project Delivery Mechanisms

By the time *Chayan* was ready for implementation on the ground, the ongoing child health project was fully functional. At the district level, CARE already had a team of three to four professionals bringing in rich experience of working with multiple stakeholders, capacity building and program management. To ensure complementarity of efforts and optimal utilization of resources, the management of HIV prevention through *Chayan* was integrated with the ongoing child health and nutrition project. Therefore, only two more members were added to support the HRBG and youth interventions.

Managerial and technical support was made available to the city teams through the project management structures of RACHNA at the state level. At the national level, Technical Specialist HIV and Technical Specialist, Youth provided leadership for the urban HIV prevention interventions.

The field implementation activities of *Chayan* in demonstration areas were carried out through partnerships with 33 local NGOs across the 22 cities. The nature of partnerships varied from state to state. In some places different NGOs were selected for different target groups, in other places all interventions were undertaken by a single NGO. In addition, formal partnerships were established with some of the corporate sector institutions such as Apollo Tyres and Indian Oil Corporation.

[16] Women engaged in sex, as a means of living full or part time, during the past three months. This includes brothel- and non-brothel-based such as those that are family based, call girls, bar girls, floating among others.

[17] These are men and women, above 18 years, who migrated into the urban and peri-urban areas in search of employment. They include individuals who: (1) are not relocated at the place of their destination, (2) are staying without families at the place of destination, and (3) visit their place of origin at least once a year (including rickshaw-pullers, contracted labours, factory workers among others).

[18] Long distance truckers including drivers and their assistants above 18 years of age found along transport routes staying away from home for at least a week.

Promoting Change: Key Results and Processes

This section presents the progress made in operationalizing the HIV prevention interventions, and the outcomes in terms of behavior change. As mentioned in the earlier section, the implementation of *Chayan* focussed primarily on development of demonstration sites. Accordingly, the operational results highlight achievements limited to demonstration areas while also drawing lessons from engagement with various stakeholders for further scale up.

Monitoring and Evaluation Design

The monitoring and evaluation design for *Chayan* included base-line end end-line estimates of key behavioral outcomes and routine monitoring of management indicators. The components of the monitoring and evaluation design are outlined below:

- Baseline and end-line quantitative surveys conducted by an external agency (behavioral outcomes and related output indicators)
- Routine Management Information Systems (MIS) for monitoring process/ management indicators from demonstration areas gathered through implementing NGO partners.

Methodology for Behavior Surveillance Surveys (BSS)

CARE conducted two rounds of BSS among target population groups in four states covering 22 cities, in 2003 and 2006. The purpose of endline BSS was to measure changes in knowledge, behavior, and perception of risk and health-seeking practices among target population groups.

BSS methodology

CARE conducted two rounds of Behavior Surveillance Survey (BSS) among target population groups vulnerable to HIV/AIDS in four states covering 22 cities and in Delhi, in 2003 and 2006. The purpose of endline BSS was to measure changes in knowledge, behavior, and perception of risk and health-seeking practices among target population groups.

Sampling universe

The universe for selecting the required sample for BSS 2003 was all mapped sites in 22 cities of four states and Delhi where the target groups reside/operate. For BSS 2006, the universe for selecting sample has been the demonstration sites in 22 cities of five states. The study provides estimates for each state (representing the selected cities) for all major indicators separately for each of the target groups.

Estimation of minimum sample size

At baseline BSS (2003), following assumptions were used to estimate the minimum sample size:

- Project will make a 10-percentage point change over the project life (15 percentage point in case of FSWs)
- The estimates are based on 95 percent confidence with the power of 90 percent
- The design effect of 2 was considered

It was further assumed that about 50 percent of the truckers/migrants population would have sex outside their families in the last three months. Thus, the minimum sample sizes were, 330 (FSWs) and 1500 (truckers and migrants) for any given state. Out of the achieved sample size for truckers and migrants, the analysis for critical indicators was used only for those respondents who were identified as at risk based on the definition *'had sex with non-marital, non-cohabiting partner in last 12 months'.*

For BSS 2006, the following key assumptions were used to estimate the sample sizes.

- Measure 10 percentage points change during project implementation phase,
- The design effect of 1.8 was considered,
- The p1 is taken as 0.5 and p2 as 0.6
- The estimates are based on 95% confidence with the power of 80 percent.

The minimum sample size thus required per state was 550 for each of the target group. For truckers and migrants category, this is the minimum sample size for those who are at risk of acquiring STI/RTI and HIV/AIDS. Those who are at risk is defined as *'had sex with non-marital, non-cohabiting partner in last 12 months'.* Hence, achieving the required sample size of 550, a larger number of these target groups may have to be contacted and interviewed about their sexual behavior to determine the risk factor. Therefore, a screening questionnaire was introduced in the end line survey and a minimal set of questions was administered to determine the risk status of the respondent. The main survey tool was administered among those who are found to be at risk. The sample of 550 for each target group was distributed proportionally to the estimated population of target group in each city within a state.

Process and Outcome Results

This section summarizes the data from BSS and interprets the changes. The operational results including reach and coverage of interventions from monitoring data is also summarized in this section.

Results from behavior surveillance survey

Risk Perception*[19] *of contracting HIV/AIDS

It is important to address the gap between knowledge and perceived risk of HIV transmission among the target groups. Though the knowledge levels among all the target groups were already high, the risk perception for contracting HIV was low. Modest improvements were made especially among Migrants and truckers, in improved risk perception.

Condom used during last sex[20]

Across the target groups there has been significant increase in 'condom use during last sex' among female sex workers and truckers with not so significant change among migrants.

[19] Data for BSS 2006 for migrants and truckers are based on those who had sex with non-marital and non-cohabiting partners during last 12 months

[20] Data for BSS 2006 for migrants and truckers are based on those who had sex with non marital and non cohabiting partners during last 12 months.

Figure 9.1: **Risk perception among sex workers of contracting HIV/AIDS.**

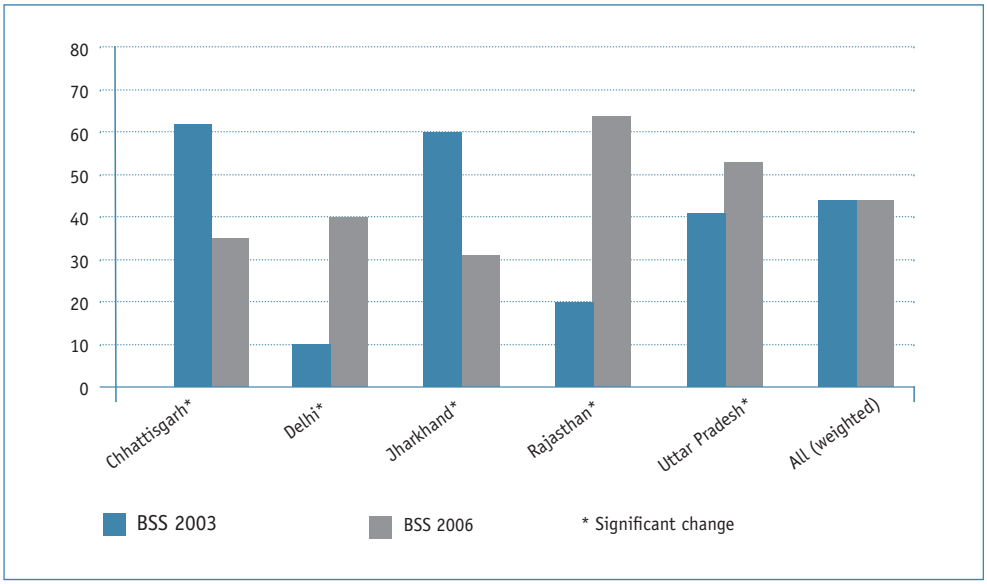
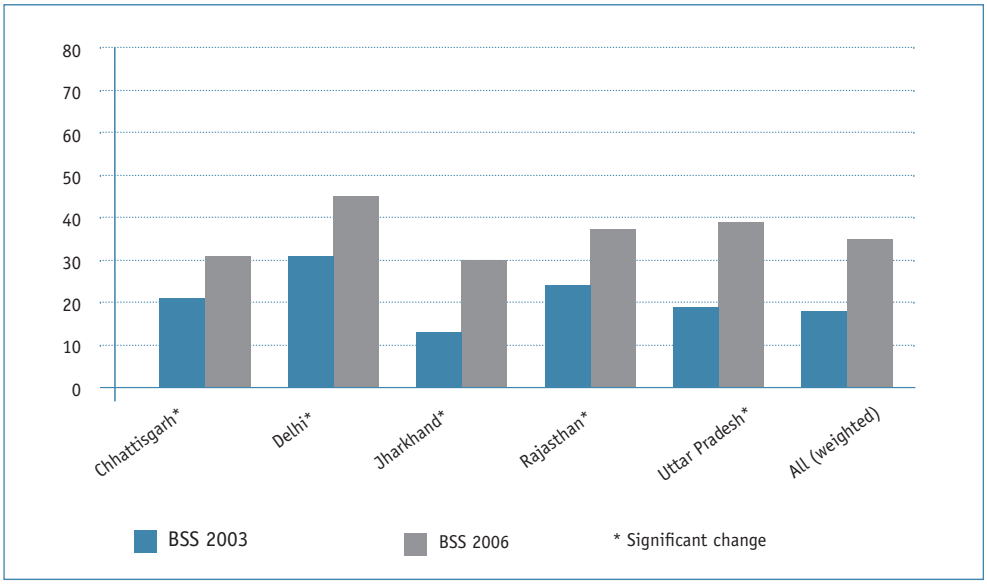


Figure 9.2: **Risk perception among truckers of contracting HIV/AIDS.**



The PE concept has proved to be a success. PEs are the backbone of the program. It is important to differentiate the PE in *Chayan* from many other projects because the PEs in *Chayan* do not receive any remuneration, not even one rupee to meet their expenses in carrying out their day to day tasks as PEs. If the PE accompanies a member of the community to the hospital for treatment, he/she does so at their own expense. The difference is in the high level of motivation of the PE and, as a result, how well the community responds to them. Seldom have we seen such dedication and effective behavior change communication – it is not only increasing awareness but the inculcation of real attitude change that makes the *Chayan* project stand out.

- Final Evaluation Report, June2006

Figure 9.3: **Risk perception among migrants of contracting HIV/AIDS.**

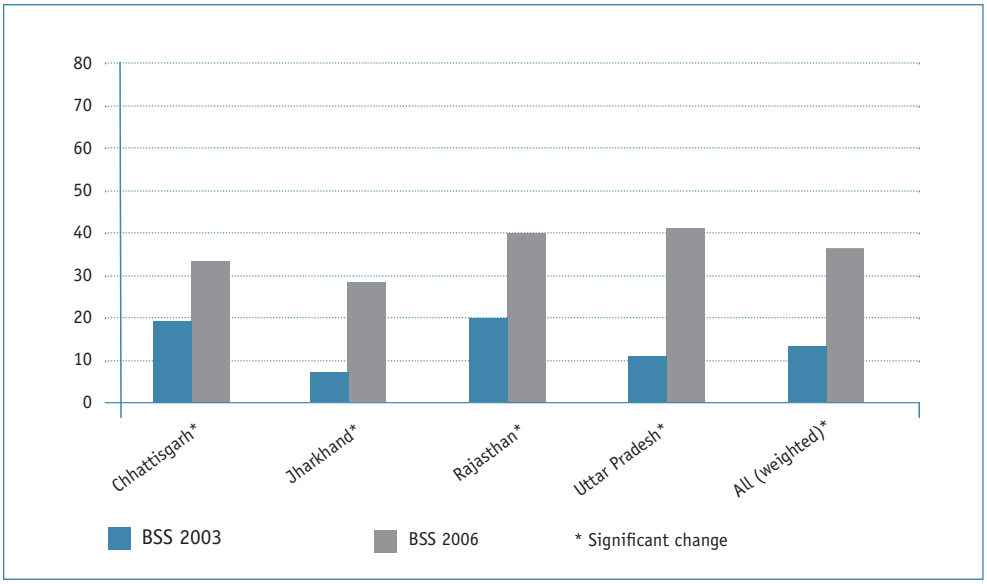


Figure 9.4: **Percentage of female sex workers who used condom in last sex.**

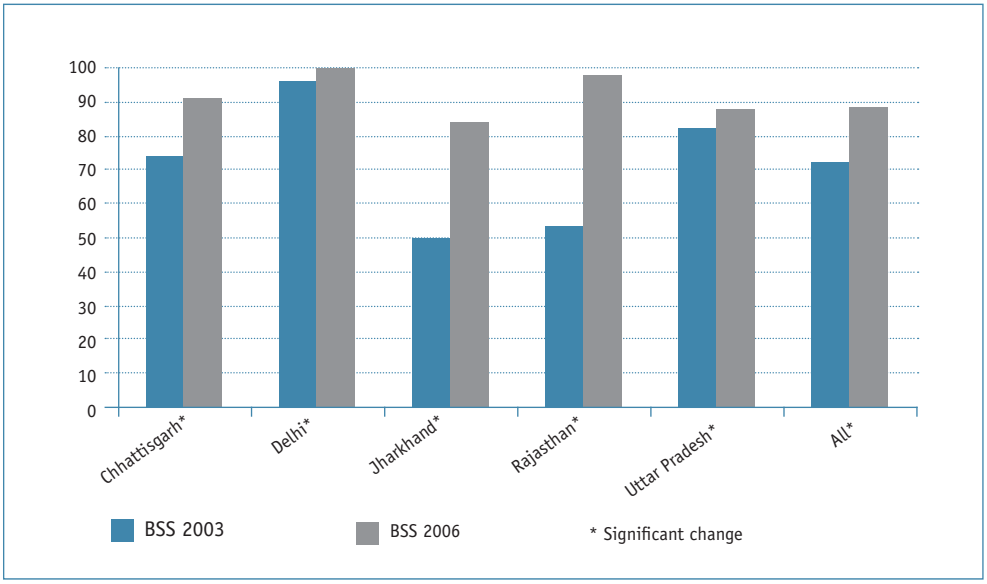
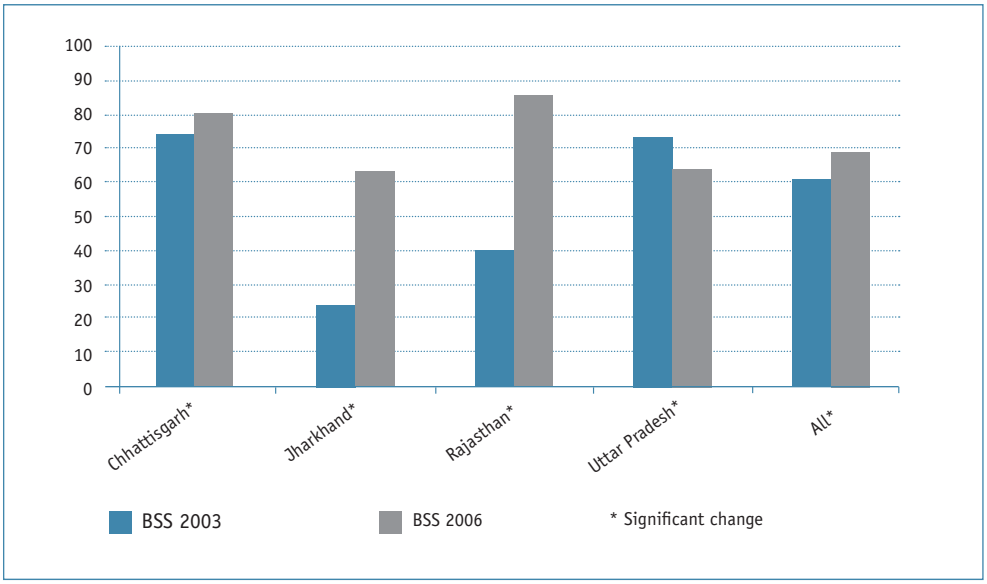


Figure 9.5: **Percentage of migrant workers who used condom in last sex with non-marital non-cohabiting partners.**



Treatment sought for STI

Among those who reported having either genital discharge or ulcers, there is definite improvement in their treatment seeking behavior during 2006 as compared to 2003. On further analysis it was seen that there was a gradual shift towards seeking treatment from qualified medical doctors among all the HRBG, but this needs further improvement.

Reasons for change

Emerging lessons tell us that a range of factors may have contributed to the above changes such as intensive efforts to increase availability of free and socially marketed condoms, intensive BCC efforts to ensure correct and consistent use of condoms, inter-personal communication through Peer Educators (PEs). In some states use of CSGs was also creating an enabling environment for community-wide campaigns for behavior change. Regular review of data, meeting with SACS and other partners was helping bring sharper focus and attention to scaling up of interventions.

Figure 9.6: **Percentage of truckers who used condom in last sex with non-marital non-cohabiting partners.**

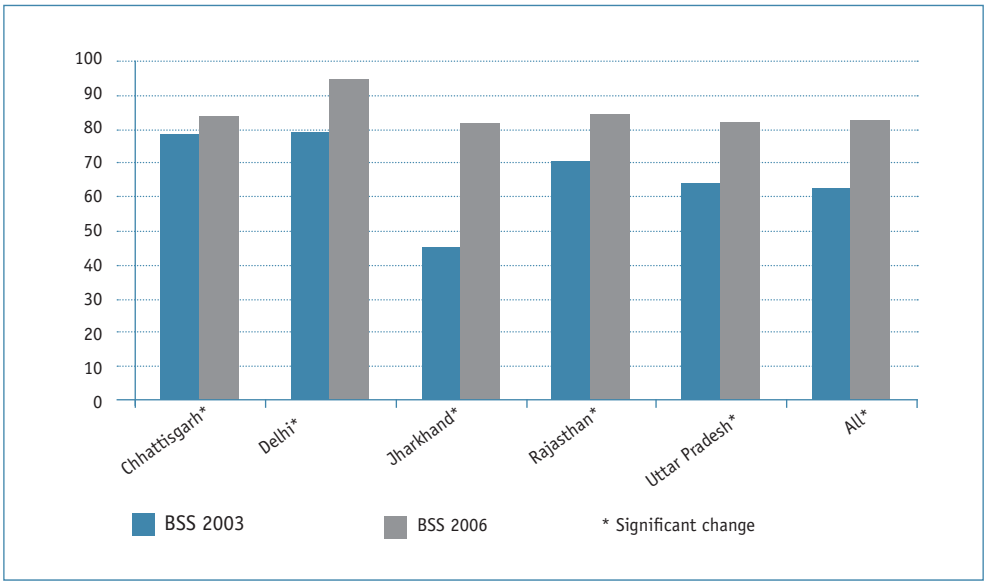


Figure 9.7: **Percentage of female sex workers who sought treatment for STI.**

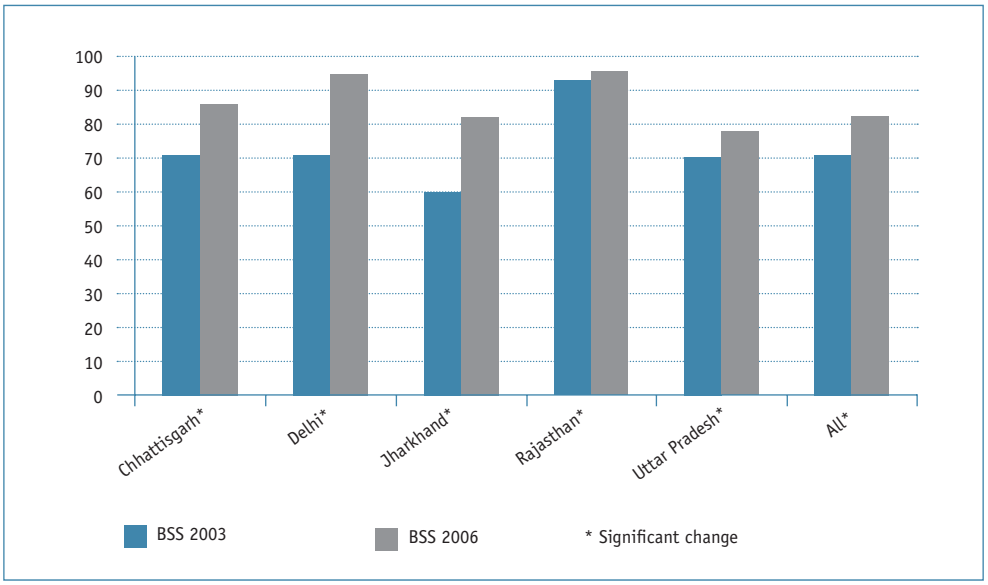


Figure 9.8: **Percentage of migrant workers who sought treatment for STI.**

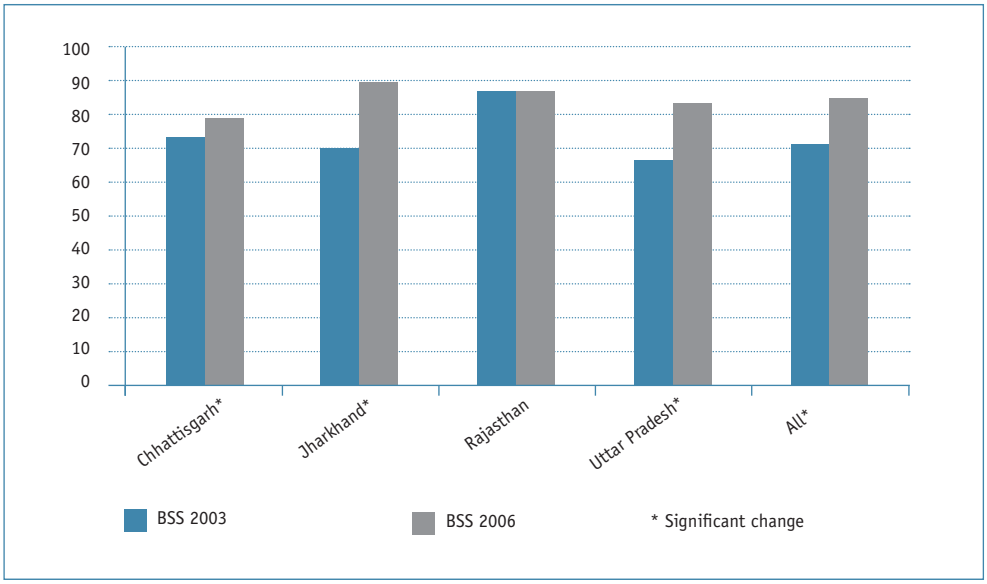


Figure 9.9: **Percentage of truckers who sought treatment for STI.**

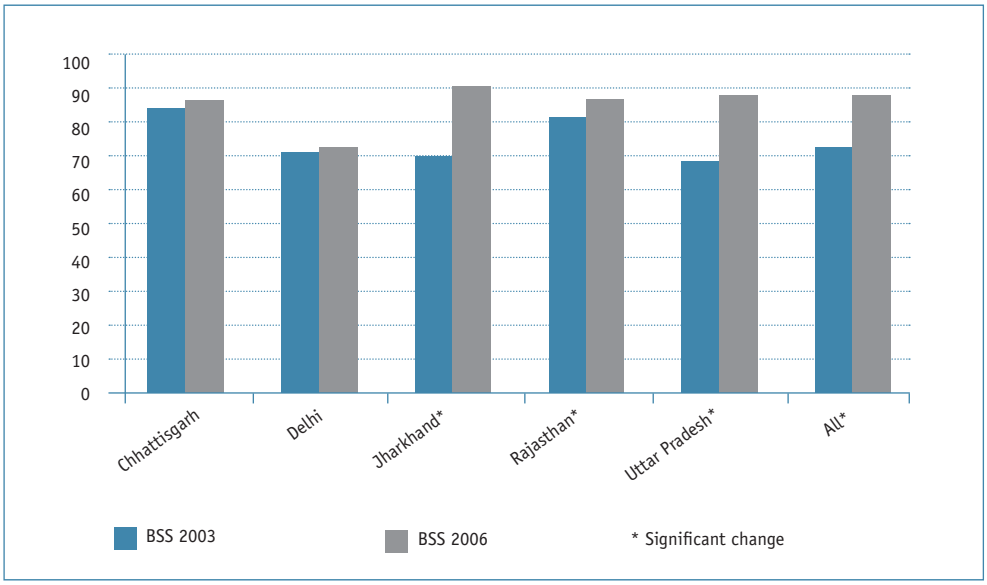


Table 9.2: **Referral and treatment outcomes for STIs**[21]

HRBG category	Obtained medicines (%)	Completely cured (%)
Truckers	98	91
Migrants	91	90
FSWs	94	82

Exposure to program inputs

Overall, 80 percent of FSWs, 68 percent of migrants and 60 percent of truckers met with someone talking about HIV/AIDS in last six months. While 65 percent of FSWs, 61 percent of migrants and 56 percent of truckers witnessed a behavior change communication (BCC) event on HIV.

[21] Among those who sought treatment

Operational Results

During the three years of implementation, *Chayan* was successful in operationalizing functional demonstration sites for targeted interventions for both HRBG and youth interventions. This section describes the highlights of key processes undertaken by the project. *Chayan* interventions were able to reach a total of 124,869 HRBG, including FSWs, truckers and migrants. The school interventions reached 70,058 youth and out of school interventions reached 73,065 youth.

Peer Educators: One of the key outputs of *Chayan* was creation of a large skilled resource pool of peer educators. PEs were selected from primary target group as well as from key stakeholders. Inputs were provided to the PE through NGO staff as well as CARE staff. These included structured training, ongoing technical inputs and supportive supervision by NGO outreach workers. The capacity-building made them confident to maintain consistency of contacts, carry out regular BCC events, organize community events and ensure linked referral and supplies.

Improved access and quality of STI treatment: *Chayan* focused on improving access of HRBG to STI treatment by establishing referral networks and currently there are 106 government and 187 private health facilities which have functional referral linkages with the target group. STI service providers were identified from both public and private sectors through resource mapping. Inputs included continued networking efforts, training on syndromic management of STI and developing a referral system to facilitate improved access of marginalized groups

Table 9.3: Reach of interventions across demonstration sites in 22 cities

State	Target Population Reached				
	FSWs	Truckers	Migrants	Youth in-school	Youth out-of-school
Chhattisgarh	541	18,242	13,763	34,028	20,639
Delhi	200	3,500	0	3,250	20,800
Jharkhand	621	4,546	11,369	4,381	5,936
Rajasthan	1,671	18,000	18,362	13,245	17,065
Uttar Pradesh	933	19,941	13,180	15,154	8,625
Total	**3,966**	**64,229**	**56,674**	**70,058**	**73,065**

Table 9.4: Peer Educators trained from demonstration sites in 22 cities

State	Trained Peer Educators				
	FSWs	Truckers	Migrants	Youth in-school	Youth out-of-school
Chhattisgarh	487	383	435	496	811
Delhi	34	53	0	49	144
Jharkhand	142	171	514	150	227
Rajasthan	130	510	597	988	1,348
Uttar Pradesh	327	481	605	972	695
Total	**1,120**	**1,598**	**2,151**	**2,655**	**3,225**

Table 9.5: Number of health facilities with referral linkages

State	Health Facilities	
	Government health facility	Private health Facility
Chhattisgarh	41	89
Delhi	6	8
Jharkhand	13	34
Rajasthan	19	18
Uttar Pradesh	27	38
Total	**106**	**187**

Table 9.6: Non-conventional condom outlets

State	Number of Non-Conventional Condom outlets		
	FSWs	Truckers	Migrants
Chhattisgarh	524	1,240	567
Delhi	11	27	-
Jharkhand	96	143	176
Rajasthan	56	274	209
Uttar Pradesh	226	252	197
Total	**913**	**1,936**	**1,149**

Table 9.7: Youth Resource Centers (YRC) and Vocational Training Activities

State	YRCs	Youth received vocational training
Chhattisgarh	22	451
Delhi	4	476
Jharkhand	12	199
Rajasthan	20	1,177
Uttar Pradesh	11	351
Total	**69**	**2,654**

to STI services and general health care. Efforts were made to sensitize the health service providers to be non-judgmental to the vulnerable groups.

Improved access to condoms: Improving access to condoms by establishing non-conventional outlets, and strengthening conventional outlets for both free as well as socially marketed condoms was a key element of the program. Linkages were established with Municipal health institutions as well as social marketing agencies to ensure uninterrupted supplies to these outlets.

Youth Resource Centers (YRCs) were established through mobilization of community resources. These were established without any financial input from the project and are managed by the community. YRCs have been able to engage the youth gainfully through various activities including linkages with vocational training and employment opportunities. In addition to providing opportunities to share and learn information related to reproductive health and life skills, YRCs organized vocational activities like handicrafts, stitching, knitting, embroidery, computer courses, automobile repairing, beautician course, tie and dye etc.

Unlocking Potential for Wider Influence: Promising Approaches and Lessons for HIV Prevention

While a few comprehensive HIV prevention interventions have been implemented in low prevalence states, *Chayan*'s uniqueness lies in its implementation model grounded in community-based approaches that is replicable across diverse contexts. More specifically, *Chayan*'s operational approaches to create a human resource pool of peer educators, NGOs and sensitized community stakeholders and to improve the program management capacities have enormous potential for further expanding the coverage of targeted interventions.

Lessons learnt

As the forward looking design, *Chayan* project ensured complementarity with the reproductive and child health intervention among general population in rural areas with targeted interventions among high risk groups in urban pockets. This not only provided scope of cross learning between urban and rural HIV prevention interventions, but also created a favorable ground for 'linking' HIV interventions through ongoing health sector programs.

Program Design and Management Structure

Chayan's focus on vulnerability and risk reduction is based on the premise that recognizing the relationship between social structure and public health fosters greater impact. *Chayan* recognized that lasting change is a process that initiates from within a community. While designing interventions consistent with public health best practices, *Chayan* ensured flexibility to local contextual variations. The project used standard public health practices set in a management culture that allowed field staff to be responsive and creative according to unique local needs.

The *'impact hypothesis'* is to reduce HIV sexual transmission through*:*

- Risk reduction and prevention, STI management and consistent condom use among HRBGs; and
- Vulnerability reduction through responsible sexual behavior among unmarried youth.

Instead of designing a discrete stand alone HIV/AIDS prevention program, CARE built on its existing child health and nutrition project that was operational across nine states in terms of institutional linkages, relationships and experiences at district level.

"I respect myself. I am proud of being a woman. Society still prefers sons, but wait till they learn hard lessons for this bias."

– Young Girl, Bhilwara.

CARE's strategic partnerships with government and NGO counterparts over many years assisted in quickly launching the interventions. For example, building capacity of Anganwadi Workers and Auxiliary Nurse Midwives, service providers and frontline workers of the ICDS and RCH programs of the GoI on reproductive and child health and nutrition, prepared them to include HIV/AIDS related messages, particularly to women in the reproductive age group.

Gender equity and stigma reduction strategies formed a critical component of all interventions. Amongst youth, specific gender issues such as women's mobility, early age at marriage, young girls realizing their right to say no to partners, were dealt within many program sites. Some of these activities were particularly empowering for young women who negotiate decisions affecting their lives within their families. In many instances, they successfully negotiated improved mobility and initiated dialogue with young men to reduce eve-teasing and not view women as 'sexual objects'.

Building NGO Partnerships

When CARE launched its HIV program in 2002, NGOs working on HIV issues were almost nonexistent in these cities. Most leading NGOs working in rural areas were less keen to take up small projects in urban areas. The disinterest was more when it came to working with HRBGs. Very few NGOs had previous experience or even exposure of working with HRBGs. Other than unwillingness to work in a "stigmatized sector", the internal capacity was also limited. As a result, it took tremendous amount of orientation and persuasion in these states to finalize partnerships with NGOs. The capacity building of NGOs was an intensive exercise, initially focussing on institution building. The training was followed by field support provided by CARE staff. It was found that "commitment" and "enthusiasm" were more critical than work experience in HIV prevention.

NGOs and Trusts affiliated to corporate agencies were explored in all the states to enhance public-private partnerships as well as to enhance the pool of organizations available for targeted interventions. Cities like Jamshedpur, Delhi, Kanpur, Udaipur, Bharatpur and Bikaner established partnerships with corporate institutions such as Tata Steel, Apollo Tyres and Indian Oil Corporation. In addition, non-financial partnerships were initiated with Steel Authority of India Limited (SAIL) in Bokaro, Bharat Coking Coal Ltd in Dhanbad, Jindal Industries in Raipur, Bharat Aluminium Limited Corporation (BALCO) in Korba, RECRON and CAMLIN in Allahabad, Reliance Industries in Ghaziabad, and Amin Welfare Trust in Kanpur.

In all, 33 NGO partnerships were established. The budget for each partner varied depending on the size of the target group covered and the extent of external support available from SACS for capacity building, communication etc. Stringent monitoring of fund utilization also contributed to optimal program performance.

Lessons learnt

Rigorous process of selection of partners and workforce and technical skill building for implementing HIV interventions was a key input provided by *Chayan* project. Availability of efficient young professionals for ongoing technical support, closer monitoring and supportive supervision was a critical element to success. Although the funding allocation to NGO partners of *Chayan* is minimal, each of them received significant capacity building inputs to the program for comprehensive HIV interventions.

Geographic and Social Analysis

Chayan partners conducted analysis through formal mechanisms (including mapping, needs assessments and social analysis) as well as informal mechanisms, including senior management reflective meetings to improve quality and program impact.

Mapping to identify sites, services and size estimation

Chayan first conducted a mapping exercise with the aim to identify geographic locations of high risk and vulnerable groups, NGOs and service providers. Qualitative methods including ethnography, focus group discussions, key informant interviews, transect walks and rapid surveys were used for triangulation at site and institutional levels. Building on this, social maps obtained necessary details of the sites once they were identified. Target group size was estimated based on these findings and informed microplanning for each of the sites.

Mapping findings provided implementers with the necessary foundation to initiate programming. Size estimates of the high-risk and vulnerable groups, intervention sites, availability of services and NGOs were generated for each of the 22 cities. However, since the mapping exercise was conducted by an external agency, staff and partners did not get the an opportunity to learn about the transmission dynamics and stakeholders until they participated in assessment activities themselves. Through the Needs Assessment and Stakeholder Analysis (NASHA) exercises described below, *Chayan* partners developed insight into the communities' social realities. It was often said, "staff and partners turned out to be the most competent mappers" as they identified several more sites and target groups.

Needs assessment and stakeholder analysis (NASHA)

In order to gain reliable information on transmission dynamics, social networks and project opportunities and constraints, *Chayan* partners conducted integrated social assessments and analyses across all cities.

The ***needs assessment (NA)*** was conducted by program partners across all sites, for reviewing vulnerabilities and risk-related factors facing HRBGs and youth. This provided additional information on socio-economic and demographic community profiles, condom availability and accessibility to medical and traditional healthcare providers. Needs assessment tools included, *Chapati* Diagram (problem prioritization), daily routine clock, disease calendar, mobility mapping, force field analysis, transect walk, in-depth interviews and focus group discussions.

The **stakeholder analysis (SHA)** systematically summarizes the range of people who individually and collectively influence risk and vulnerabilities of HRBGs and youth. The steps included:

- Verification of sites in reference to its target population(s)
- Identification of stakeholders
- Establishing rapport through team building exercises
- Measuring stakeholder interest in the proposed interventions
- Ranking stakeholders according to their importance and influence among HRBGs and youth and illustrating this on an importance/influence matrix
- Preparing a matrix that illustrates stakeholders' level of importance, influence and expectations among HRBGs.

Exploration into power dynamics helped expose the many facets of powerlessness. NASHA was a powerful participatory process which was found to be very useful in highlighting the issues of unequal power relations, exploitation, stigma, violence and poor negotiation abilities of vulnerable groups and recognizing the need for addressing the felt needs of the target group. For example, instances of forced anal/oral sex and of clients not paying/paying less were reported by sex workers. Poor negotiation skills of sex workers were found to be affecting their ability to insist that the client should use a condom for protection from HIV infection. An important contribution of NASHA was that it helped the staff of CARE as well as the NGOs not to be judgmental and increased their sensitivity to the issues of sex and sexuality. As one *Chayan* staff noted, "we stopped paying attention to *who*, and focused instead on *how* HIV is spread.... we identified [target groups] as human beings that are vulnerable (and not risks)." Identifying precise sexual transmission dynamics specific to a community while operating discretely and compassionately has made *Chayan* the unique program that it is. In addition, there was recognition of vulnerabilities of HRBG that affect their ability to protect themselves from HIV, and this provided a platform for bringing various stakeholders to negotiate with each other. In some cities, based on NASHA outputs, the migrant populations were linked to insurance schemes and information on government entitlements was provided to them. In other cities it revealed the need to be flexible to include other groups in the target groups. For example, many women who sell sex were not identified as sex workers. These were some daily wage earning women such as vegetable/fruit sellers who succumb to providing sexual favour to the employer to have assured work. Consequently, these individuals were difficult to reach and rarely used condoms with regular partners.

Through NASHA, *Chayan* partners **identified formerly invisible yet influential stakeholders** that varied across states and specific sites which included transport associations, labour unions, police officials, mechanics, health care providers, scrap dealers, pimps, barbers, *dhaba* owners, fuel station staff and rickshaw-pullers, among others. Based on their level of influence and importance, *Chayan* partners organized them according to their interests and needs. For example, they placed *Chayan* messages on the agenda of formal meetings such as labour-related assemblies and drivers' association meetings. As one staff indicated, "we built rapport with the community people and then introduced the ideas in ways that fit into their every-day lives, so it was as normal as anything else." NASHA findings facilitated local and city level planning, prioritization and resource allocation decisions. Lessons from NASHA were shared with SACS and its partners for replication.

Promoting Behavior Change

Chayan's community-level model grew out of the realization that despite considerable risk reduction which occurs through individual-level behavior change approaches, attention to social influences can be transformatory. Hence, in addition to reducing individual risk and vulnerability, the project attempted to change community perceptions and sensitivities, relying on the

A rickshaw-puller spreads the message of condom use as he travels around the city

use of peers and social networks to disseminate information. Informed by the BSS and NASHA exercises a BCC strategy was developed through consultative processes. Given the limited resources, different communication channels and opportunities were leveraged by the project teams to enhance awareness with appropriate content. Initial activities of rapport building, needs assessment and social sanction took more time due to the stigma and taboo associated with the target groups as well as sexuality issues. Context specific and culturally acceptable behavior change process facilitated the community acceptance of the project activities. Messages on 'Abstinence, Be faithful and Condom use' were reinforced through all BCC initiatives.

Some of the opportunities used for awareness generation are as follows:

- Games and story lines were locally developed and promoted. Events like street plays, video shows and infotainment programs were organized.
- Opportunities available through Health day, World AIDS day, International Labour Day and Road Safety Week were used to generate awareness on HIV/AIDS through mid-level media activities.
- Cultural and religious events like '*Raksha Bandhan*' (a festival when sisters pray for their brothers and in turn seek their love and protection) and '*Vishwa karma pooja*' (a ceremony when industrial laborers worship their machines) were used to promote awareness and a favorable environment for HIV prevention activities.
- Target groups are involved in NASHA and designing of BCC strategies

Street play in Jehangirpuri, Delhi

Messages on gender equity formed a critical part of all BCC initiatives. Rejecting masculinity and femininity stereotypes that came in the way of participation of youth, especially young women were addressed through training, innovative strategies like picnics for young women and men where they openly shared and challenged their own biases about each other.

"We always thought of ourselves, never about our wives. They have desires too, but unlike us society curbs their mobility and forces them to make sacrifices".

The final evaluation noted that, "unlike other projects, *Chayan* created empowerment rather than dependence.[22]" The evaluation further states, through genuine NGO and community stakeholder controls, "in very real terms the community served has assumed ownership of the program."

It goes without saying, behavior change is judged by its impact. As observed through comparing BSS carried out by CARE during 2003 and 2006, reported condom use at last sex shows significant increases across all three HRBGs over three years (BSS by CARE). Treatment seeking behavior, and risk perception is also demonstrating positive change.

Peer Educators

Peer educators not only give information about HIV/AIDS, but are also true friends... They are lamps in their own right, spreading the light of knowledge.[23]

[22] Anderson, Mary Ann, et al., Reproductive and Child Health, Nutrition and HIV/AIDS Program (RACHNA): Final evaluation. 2006.

> "I have to save the people in my basti (slum) from [HIV/AIDS] dangers which can take their lives... I have to help them look into the future, and be prepared. I cannot rest."
>
> Peer Educator, Ranchi

Though the peer educators are not remunerated, they are highly motivated and generate enthusiastic community responses at a range of events. According to the authors of the evaluation in 2006, "it is the BCC strategy, especially via the peer educator, that makes the field work so very remarkable."

Given the conservative environment, in which they worked, several peer educators struggled with the sensitive nature of their community mandate. As one CARE staff indicated, "Peer educators figure out ways to talk about HIV/AIDS without making it public." For example, in many communities they launched a "*Khul Kar Baat Karenge"* (let's talk about it openly) campaign while in others they did not initially talk about reproductive and sexual health. In such cases, they use livelihoods and life skills messages as points of entry. Social norm-changing events include community dialogues, street theatre, music, fairs (*melas*), and innovative games. The reflective enquiry and interactions between peers and target groups took place regularly. Through these reflective sessions, peer educators monitored questions, myths, and misconceptions that arose among stakeholders and target groups. These were documented in a daily diary and shared in peer educator meetings, with outreach workers and CARE staff. As seen in Table 9.4, more than 5,000 PEs were trained across the five target groups. Selecting, training and retaining PEs was a challenge. However, local NGO partners evolved ways to appreciate their work through strategies such as giving them diaries, placing sign-boards specifying their identities as PEs for *Chayan*.

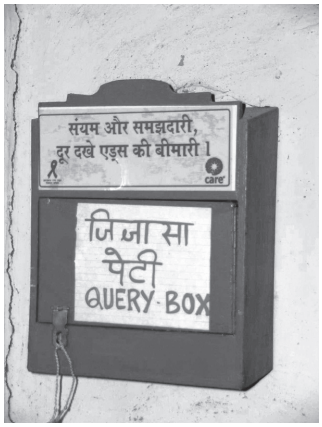
Youth Resource Centers

A Youth Resource Center (YRC) is a fun and learning center that provides a forum for young girls and boys for strengthening their skills for leading a healthy and happy life. It is predominantly a community-owned and managed facility where young people can have access to key information and counseling on health (especially reproductive) and other life skills issues. Besides learning, these YRCs can be used as recreational facilities and simultaneously linked with institutes providing vocational training or career guidance. Overall, YRCs helped enhance self-esteem and confidence of individuals and encouraged responsible and informed decision-making.

All cities have one or more fully functional YRC. Communities contributed to facilities for 60 out of the 69 YRCs where youth acquire information and counseling on sexual and reproductive health issues, including HIV/AIDS. The strategy of YRCs was intended to reach out to youth who are out-of-school for vocational and career guidance. Program evaluators noted that the YRC participants had "impressive levels of knowledge, attitudes and community ownership."

Process in practice: Creating effective youth resource centers

- Develop a well planned social-sanction strategy before implementing activities.
- Build rapport with stakeholders (teachers, parents, religious leaders) to obtain social sanction.
- Visit gatekeepers regularly.
- Use attractive local media such as street plays. Make regular door-to-door visits to meet with parents and identify new youth that have been left out.
- Apply Asset-Based Community Development (ABCD) approach in which partners build on assets that are available in the community, such as YMCA, community gyms, sports clubs and caste associations, rather than importing new structures.
- In addition to social sanction, ensure system sanction by involving government officials such as the education officer, sports officer, municipal corporation officer.
- Build links with relevant organizations such as vocational skills training, the district literacy committee, banks and the district industry center in which short term entrepreneurship are attained.
- Establish a community stakeholder group (parents, teachers, political leaders) to manage the YRCs with the youth.
- Regular activities for youth and by youth such as vocational training; slum clearing or chlorinating sewage.



An opportunity for anonymity in question on HIV/AIDS – A query box in the YRC in Kanpur, (UP)

Management committees helped YRCs to become independent by charging nominal membership and fees for vocational training. In a couple of cities even the local government (municipality, District Industries Center and District Urban Development Agency) funds and schemes were tapped to support the training programs. The trainings range from tailoring, stitching, knitting, embroidery to *mehendi*, beauticians' course, jute work, handicraft making, electrical repairing, TV repairing and motor rewinding. These were mostly conducted in collaboration with *Jan Shikshan Sansthan* and other local vocational training centers. Events like quiz competitions, debates, information *melas* (fairs) and *maa-beti sammelan* (mother and daughter meetings) are periodically organized in YRCs.

Life Skills Education (LSE) curricula, designed by UNFPA, and *Prerna*, were used during the structured sessions with youth peer educators and target group. Specifically, it builds personal and social skills required for young people to lead positive, productive and healthy lives. It was assumed that use of life skill approach would make the youth interact better on otherwise forbidden sexual and reproductive health (SRH) topics and reduce their vulnerability in critical moments of life where they would always have the risk of making a wrong choice under multiple influences. The LSE was imparted through structured sessions in the YRCs and schools and colleges. The trained core teachers, outreach workers and in some places peer educators conducted the sessions. Emphasis was on Abstinence and Be Faithful in all such training events and BCC activities to promote responsible sexual behavior amongst youth.

Realizing aspirations for a better life - Negotiating delay in age at marriage

Little did Rihana know that in spite of being a Class 4 drop out she would some day do what she could never have dreamt of. She also belonged to a very conservative family where women seldom expressed what they felt and sacrifice by women was the glorified virtue. The turning point was her involvement in *Chayan* a program for addressing vulnerabilities of youth to HIV/AIDS. Despite initial reluctance, her family got convinced to send her for the activities organized from time to time involving all youth of her community. Rihana gradually shed her inhibitions and participated actively in all sessions where she learnt that HIV/AIDS is preventable and all it takes is correct knowledge and a determination to practice all preventive behaviors. She enjoyed the life-skills sessions and began relating how she could use these in her day-to-day life. Rihana's growing confidence was however put to task when her parents began insisting that she get married. However the newfound space and knowledge she had gained from life-skill education made her stronger and she was able to make her parents understand the risk of marrying her early. Today Rihana's family stands by her and takes pride in her knowledge. Moreover, they too have gained knowledge about HIV/AIDS and feel safer and more powerful when they see others who are yet to open up to the world around them.

Condom Promotion

Chayan interventions offer a choice of both free as well as socially marketed (SM) condoms in and around the intervention sites through traditional and non-traditional outlets. In order to complement demand generation with services, a wide network of free and SM depots in coordination with the SACS and AM agencies like Hindustan Latex Limited (HLL) and Population Services International (PSI) were established. Condom were placed in these outlets and replenishment was ensured through networking with social marketing agencies. Free supplies from the Government dispensaries and hospitals were procured and placed with peer educators, NGO workers and non-traditional outlets like petrol stations, barber salons, bars and wine shops.

Capacity building through regular meetings and training sessions with peers and NGO workers was undertaken to improve understanding on benefits of condom use, demonstrate correct use of condom and to provide information and support in overcoming social and personal barriers to condom use, especially lack of negotiation skills or peer pressure. All the PEs and NGO workers are linked to the traditional and non-traditional outlets. Condom promotion for youth was not focused, rather only limited to a subset of high risk youth, such as those engaged in multi-partner sex, transactional sex and frequent sexual encounters. All condom promotion was complemented with 'abstinence' and 'be faithful' messages.

Prevention and Management of Sexually Transmitted Infections

Chayan focused on four aspects of STI prevention and management.

- Activities to generate awareness of STIs while emphasizing both long-term consequences of such infections and preventable and treatable measures.
- Establishment of a referral network for treatment by interacting with existing healthcare providers, usually the public sector health facility in the city. This includes training on syndromic management for providers.

- Follow up and tracking to improve treatment seeking and compliance to treatment.
- Ensuring condom availability.

In Chhattisgarh, the STD clinic supported by Transport Association is now used as a demonstration site for other SACS-supported NGOs. In Durg, *Chayan* supported sex workers to run their own clinics. The sex workers themselves appointed doctors with a minimum fee covered by community members. Government supported by providing supply of basic drugs and condoms.

Early detection and management of STIs are critical steps for HIV/AIDS prevention. Since a very large proportion of those actually infected with STIs do not generally seek appropriate medical interventions, changes in treatment seeking behavior are essential. CARE's BSS data shows that there has been a minimum of 10 percent increase in STD seeking behavior in all three groups. Private and public health facilities helped to ensure higher quality and accessible STI services that are linked to condom promotion actions.

Training on syndromic management of STIs/RTIs was conducted for the qualified doctors where laboratory facilities for diagnosis were not available. Training sessions were facilitated either from CARE or through the involvement of SACS and Indian Medical Association (IMA) for health service providers (HSP) on syndromic management of RTI/STI and orientation of the Registered Medical Practitioners (RMPs) to enhance the process of referrals.

Youth-friendly Health Services

An important gap identified during NASHA and supported by a number of other studies on adolescent reproductive and sexual health (ARSH) is the absence of youth-friendly health services (YFHS) sensitive to youth specific issues and problems. Unlike HRBG intervention, STI/RTI treatment among youth was not an aggressive intervention. The emphasis of YFHS capacity building was to equip the service providers to handle myths and misconceptions and counsel youth in a sensitive, empathetic, friendly, non-judgmental and confidential manner.

Family Health International's (FHI) training modules were used for skill building of health service providers in order to ensure provision of youth friendly health services. Over the project period, 206 qualified health service providers were trained on YFHS.

Community Stakeholder Groups (CSG)

Social networks among high risk and vulnerable groups are a source of emotional support and often shape the social norms in their respective communities. Stakeholders, including opinion leaders disseminate messages to friends and other members of their social network.

CSGs were identified after stakeholder analysis. Representatives of civil society organizations, religious groups, transport associations, rickshaw-pullers, *dhaba* owners, labour unions, sex workers' networks, police, pimps and NGOs represent typical CSGs in *Chayan*. For youth, CSGs consist of teacher-parent associations, elder siblings, youth leaders, youth associations, and representatives of NSS (National Service Scheme). Serving as platforms to position behavior and social change activities, CSGs facilitate responsive community action in relation to social norms, policy change and service delivery. In most instances, NASHA exercises led to actions adopted by the CSGs. For example, sex workers and migrant populations acquired government sponsored entitlements, through CSG advocacy messages, such as life insurance schemes after NASHA findings were identified as a need in Chhattisgarh.

The transport associations operating in the trucker program sites were among the most active CSGs. They generally consist of the truck owners, transport agents and executive members of the transport organization. The Sanjay Gandhi Transport Nagar Association in Delhi provided a space for smooth running of project activities in the first year of the intervention itself, including activities related to social sanction. They organized 'infotainment' programs and used film stars, dancers and singers to relay behavior and social change messages, provided space for STI clinic and counseling centers and established condom outlets for free and socially marketed condoms, including condom vending machines at sites accessible to truckers. In Udaipur, transport organization holds bi-annual meetings where *Chayan* partners participate to discuss HIV/AIDS programming plans.

In order to deliver sexuality-related messages to youth, *Chayan* staff interfaced with political leaders and social leaders since they carried tremendous influence on communities. Though intensely resistant at first, all leaders became supportive of the efforts.

Supporting and Strengthening SACS

Systematic and proactive engagement with SACS and Education Departments at the state level facilitated ownership and commitment to improve the HIV prevention programs. In UP, the involvement of police officials provided an enabling environment for interventions. A communication issued by the Inspector General (IG) of Police directed all officials in the Department to support the efforts of *Chayan*. Similar communication was issued by the District Magistrates of some of the cities in UP to the District Inspector of Schools (DIoS). Similar directives were issued from district level officials of all other cities. In JH, state level sensitization event was organized in collaboration with SACS to orient legislators, media, officials of Education Department, and NGOs on the enabling role to be played by them to facilitate HIV prevention interventions.

The mapping findings, BSS and NASHA exercises conducted by *Chayan* were highly valued by all states as this was the first time that mapping was done in some of these cities. In all the states, the findings from BSS were widely disseminated and used to inform the demonstration efforts. In JH, the terms of reference and

tools used for mapping and BSS informed the completion of the process in the remaining cities and in rural areas. SACS was regularly informed and updated with data from the field on the changes in distribution of target populations so that interventions could be scaled up accordingly.

One of the efforts in JH and UP has been to ensure that SACS and its partners cover TIs among all the identified HRBG sites. UPSACS requested CARE to provide support to scale up TIs among those target groups not covered by *Chayan*, such as IDUs and MSM. Partnerships and collaborations initiated with corporate NGOs in UP and Delhi provided a platform to scale up the urban interventions. In JH, close coordination has been established with the State HIV Prevention Consortium, which has partners already working in three out of the four cities in the state.

Since the interventions with youth were facilitated mainly by the Education Department, efforts were made to engage key officials to work closely with SACS to implement the School AIDS interventions. For scaling up youth interventions, *Chayan* is also collaborating with a wide range of partners including Municipalities, District Urban Development Authorities (DUDA), NGOs, ICDS and others to ensure reach to entire universe.

Finding Pathways for Excellence: Program Evolution and Learning

Chayan evolved through ongoing reflection and analysis of data and field experiences. RACHNA's approach is to be simultaneously reflective and rigorous in the use of both numeric and narrative data to inform programmatic decisions. Reflective sessions were regularly scheduled across different levels with an aim to focus on actions while bearing in mind the broader contextual complexities that would heavily shape their interventions.

Shifting from Targeted to Composite Interventions

As the project implementation began in 2003–2004, the ground realities started surfacing. Through closer interactions and in-depth understanding of the primary target groups, it was clear to the implementing staff that unless we saturate the geographic area with interventions reaching all the key target groups, it would be difficult to reduce the transmission of infection. For example, a sex worker may have sex with her lover, pimps and husband apart from paying clients. Thus they all need to be targeted with interventions. Similarly, in the migrant and trucker sites there may be a subset of MSM and IDU populations who are equally vulnerable and need to be reached. Therefore, it was the most logical step forward to reach out to all the vulnerable population in a geographic area rather than use the target group specific approach.

The transmission dynamics started becoming clearer with the conduct of NASHA exercises. Subsequently in 2004, *Chayan* undertook yet another exercise of 'situational analysis' and further updated the denominators on different types of HRBGs existing in a mapped site. It helped to identify all the HRBG segments in a given geographic area that are directly or indirectly responsible for pacing up

Composite Intervention Approach

Advantages:-

- All the target groups in a defined geographic area can be covered with the same level of intervention
- Maximum reach with minimal resources
- The unit of intervention will be based on the routes of transmission and not the target population. It would lead to stigma reduction. ('targeting behavior not person' approach)
- More people involved in the community led processes can create a greater vibration in relation to demand of services
- Representation of different target groups in planning, execution and monitoring of the services would lead the program a more community led process

the spread of the virus. Emphasis was placed on identifying the sexual network among different HRBGs and the transmission dynamics operating between them. In this realm, the project decided to use its TI platform to roll out a composite intervention strategy for saturating the demonstration sites through the existing resources. This involved:

Situational Analysis (SA): In all the 22 cities the situational analysis mainly focused on:

- Identifying and mapping the newly evolved sites (new sites as well as sites with population shifted from any old site) and the size of high risk population along with verifying the denominators.
- Identifying the allies and organizations working in the field of HIV/AIDS and reproductive health in any given area and mapping different private and public service providers in the cities
- Identifying different routes of transmission of the virus and the roles of different groups in transmission

Peer Education (PE) – PEs who were involved in targeted interventions for truckers, migrants and FSWs were encouraged to interact with the other HRBG in the geographic areas (like MSM, IDU, Eunuchs etc).

Enabling environment – The component of enabling environment was more open and overarching. People involved in transport associations and in other unions were also oriented in transmission dynamics and effectiveness of composite intervention in protecting their fellow workers and colleagues from the virus.

Challenges Faced by *Chayan*

The implementation was confronted with some predictable and some unforeseeable challenges. While there were context specific challenges, many were common across the states.

- **Size estimation:** It presented a unique challenge since it was not possible to ascertain precise denominators to analyze changes. For example, the geographic mapping exercise provided estimates of both the numbers of

population and sites. However, when NASHA exercises were carried out, several more individuals and sites were identified resulting in ongoing increases in size estimates. Triangulating data would be more useful in future mapping efforts.

- **Identification of suitable implementing partners:** NGOs with prior HIV/AIDS prevention experience were almost non-existent in most cities. Efforts to build technical capacities, sensitivities and institution building were required before the NGOs could assume responsibility for project deliverables.

- **Quick initiation of intervention, following problem analysis:** Following multiple methods for behavioral, social, stakeholder and resource analysis has been useful but it was more of a 'learning by doing' process, which actually delayed the implementation of intervention with targeted HRBGs.

- **Identification and reach to most vulnerable subgroups:** As the program evolved over time it was apparent that there were subsets of the primary target groups who were more at risk given the diverse set of vulnerabilities faced by them. For example, it was extremely critical to reach and reinforce preventive action with a sex worker who was having large number of partners, indulging in anal sex, suffering from frequent STIs and was old with poor negotiating powers. Similarly among the truckers and migrant population, there was a subset of the associates and helpers of the truckers who also needed heightened emphasis given the existing hierarchies which place them at more vulnerable positions as compared to the truckers. Therefore, it was critical to understand the transmission dynamics between the target groups - identify the subsets of the target group who are contributing most to the transmission of STI/HIV and reach them with information and services. Assessment of transmission dynamics in the existing intervention sites revealed the presence of difficult-to-reach subsets of truckers, migrants and youth such as MSM and IDUs. Reaching these population groups has been challenging.

- **Sustaining Peer Educators:** Peer educators formed the central strategy for interpersonal communication with the target groups. Care was taken while identifying PEs to ensure that motivated individuals are selected through needs assessment process. Yet, the turnover among PEs has been significant, especially due to their mobile nature. To cope with the dropouts, the project ensured an ongoing process for recruiting new PEs and to build their capacities.

- **Establishing referral networks for STI services:** Although in urban areas, private and public health facilities were available, the access to marginalized groups was an issue. There were attitudinal problems among health service providers. Many of them were less sensitive to the sexual health problems faced by these vulnerable groups and often ended up being discriminatory and judgmental. Public health facilities were open for a limited period of time in the day, did not provide free medicines and counseling aspect was inadequate. Private facilities were expensive and many of the private practitioners were not qualified.

- **Scale up of youth interventions:** Unlike the targeted interventions among HRBGs, the interventions among youth did not have a single platform for facilitating scale up. While multiple government departments, including SACS, Education, Women and Child Development, Youth Affairs and Urban Development Authorities, had some initiatives targeting youth, but sexual and reproductive health was not very high on their agenda. Even among NGOs and other civil society organizations, there were major resource and capacity constraints to take up youth interventions at large scale.

- **Program monitoring:** Given the mobile and hidden nature of the target groups, tracking the effects of program inputs was a challenge. It was a challenge to ensure ongoing tracking of the target groups and to keep the denominators updated. Tracking of referrals of STI cases and following up for completion of treatment presented many challenges. With the mobile nature of the target groups, the follow up on treatment outcomes became very challenging especially amongst the truckers.

- **Assessing the effectiveness** of *Chayan* presented challenges since it required measuring larger social changes through individual level measurements. Additionally, obtaining large enough sample sizes to detect significance of change added new challenges to community level evaluation of this kind. The lack of control sites did not allow *Chayan* to assess it's level of attribution to program outcomes. A control group could not be included in the evaluation design in view of the resource limitations and the unavailability of a 'true control'.

Towards New Horizons: Conclusions and Way Forward

In India's poorest, most populated and vulnerable states, *Chayan* is a model that is both precise in terms of its objectives and unconventional in terms of creative actions and innovation necessary to manage the needs and variations at a vast scale. CARE's extensive presence on the ground, well established linkages with communities and civil society and coaching and mentoring capacities in large scale operations has allowed reach of interventions with quality in a short span of time. The lessons and experiences from this project are of immense value for future HIV prevention efforts in these states.

By working with communities, in contrast to merely individuals in target groups, the project shifted social norms, social structures and policies that surround individual risk behaviors. *Chayan* offers lessons in moving from the individual focused approach to a community focus, facilitating sustained behavior change and in facilitating an environment that supports safer behavior. While the environment was found to be important, it was also evident that merely focusing on environmental aspects, such as empowerment or policy change alone was insufficient. It also simultaneously strengthened the quality and accessibility to risk reduction services including STI treatment. Activities that linked reflection with action contributed to innovative solutions. Such reflective engagement inspired *Chayan* partners, peer educators and stakeholders to ensure change within their communities that would last long after the life of the project. As

an early entrant in the highly vulnerable states, *Chayan* project has a large quantum of unfinished task. There is a strong need to saturate the coverage of interventions with high-risk behavior groups, as well as to scale up the HIV prevention approach to general population. The composite intervention approach, which is informed by the operating transmission dynamics in a geographic area, needs to be strengthened. Evidence needs to be generated so that this approach can gradually replace the targeted intervention model.

There is a need to mainstream HIV interventions through ongoing RCH II[24] implementation, through close integration of reproductive health and HIV components and further expand the reach to general population. The current experiences should be complemented by additional interventions aimed at reducing risk of drug-use related HIV vulnerabilities including injecting drug use and strengthening sexual health interventions by including 'males who have sex with males interventions. These additional inputs would go a long way in making the current intervention more comprehensive, if complemented with HIV/AIDS care and support initiatives. While *Chayan* made a remarkable beginning in creating models for HIV prevention work in the most vulnerable states, there is significant unfinished work when the project comes to a close in December 2006. The implementation time of over three years available to the project did not allow *Chayan* to make significant contributions to scaling up of interventions beyond the demonstration sites. Moreover, the approach to multi-sectoral collaboration needs to be further strengthened at all levels to bring the HIV agenda as a priority among various government departments and programs, corporate sector institutions, and civil society.

We would like to extend our greatest appreciation to the sex workers, truckers, migrants, youth and the many stakeholders who participated in the urban *Chayan* program for sharing with us their insights, experiences and aspirations.

Chayan Project: Findings from Behavior Surveillance Surveys

Female Sex Workers

Indicators	Chhattisgarh		Delhi		Jharkhand		Rajasthan[25]		Uttar Pradesh		ALL (weighted)[26]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
N	*315*	*311*	*252*	*193*	*330*	*428*	*331*	*543*	*329*	*550*	*326*	*800*
Knowledge												
Percentage knew that consistent Condom use reduces the risk of HIV infection (among those who heard about HIV AIDS)	90.1	94.7	98.4	93.8	90.5	79.9	77.0	92.6	95.3	92.2	91.6	90.3
Percentage correctly aware (with no incorrect knowledge) of all 5 ways of HIV transmission[27] (among those who heard about HIV AIDS)	0.0	0.0	0.0	0.0	0.0	0.5	0.3	6.3	0.0	0.5	0.0	0.8
Percentage rejecting at least two misconceptions about reducing the risk of HIV infection (among those who heard about HIV AIDS)	71.0	73.3	67.7	78.2	53.9	64.3	71.3	50.5	73.8	86.2	69.0	75.8
Behavior												
Consistent condom use with Paying Clients (used condom in all the sexual acts with paying partners during last 24 hours)	85.2	95.9	84.1	99.4	70.3	75.7	60.3	86.8	78.7	85.1	75.5	86.1
Condom use in Last Sex -												
- With any type of partner	73.6	91.0	95.7	100.0	49.7	83.9	54.4	98.0	82.4	87.3	71.8	88.5
- With Paying Clients	69.8	90.4	93.6	100.0	47.3	80.8	51.1	95.8	78.7	85.6	68.5	86.7
- With Non - paying clients	38.4	20.9	78.3	24.9	11.7	42.1	29.3	75.5	54.0	25.8	41.5	31.6
Self Reporting of STD Symptoms												
Percentage suffer from -												
- Genital Discharge	19.4	6.1	9.5	4.1	24.8	8.4	27.8	26.2	13.4	12.5	18.0	11.0
- Genital ulcers/sores	16.8	8.4	10.7	4.7	17.0	12.6	19.0	34.4	8.5	8.5	12.4	11.1
Percentage had sex with any partner while suffering from STDs	74.7	43.9	68.1	62.5	30.6	57.5	76.9	63.1	53.8	52.4	54.2	52.4

[25] Sample represents mainly one city (Jodhpur) in which accounts majority demonstration area in the state
[26] Total sites in each state are used as weights
[27] Five ways of HIV transmission - Sex with multiple partner or heterosexual acts; sex with infected person; homosexual or other form of sex; infected needles; infected blood

Indicators	Chhattisgarh		Delhi		Jharkhand		Rajasthan[25]		Uttar Pradesh		ALL (weighted)[26]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
N	*315*	*311*	*252*	*193*	*330*	*428*	*331*	*543*	*329*	*550*	*326*	*800*
Perception of Risk												
Perception of contracting STDs	17.1	11.3	6.0	30.6	22.3	6.8	4.5	2.9	12.8	20.9	14.0	14.6
Perception of contracting HIV/AIDS	61.5	34.4	9.5	39.9	60.0	30.8	20.0	63.7	41.1	52.5	43.5	44.3
OTHERS												
Time of Condom Use (Before first penetration)	80.0	91.3	95.2	100.0	60.9	79.2	98.3	93.5	97.6	88.0	88.4	87.6
Median age at sexual debut	16.0	17.0	17.0	16.0	17.0	18.0	16.0	18.0	17.0	17.0	16.8	17.3
Median age at first commercial sex	22.0	25.0	23.0	18.0	24.0	20.0	19.0	20.0	20.0	19.0	21.0	20.7
Mean number of paying clients per day	3.0	3.3	2.9	3.2	1.4	3.2	2.8	5.0	2.6	3.6	2.4	3.5
Mean number of paying clients in last 7 days	9.1	16.2	17.4	21.7	7.1	15.6	16.8	24.4	10.9	14.9	10.8	16.2
Mean number of non-paying sexual partners in last 7 days	2.8	2.7	1.0	2.8	1.2	4.7	1.4	5.1	1.1	3.4	1.3	3.6
Process Indicators (among those who are at risk)												
Percentage heard about STD*	85.1	93.6	86.9	95.9	86.1	88.1	86.7	98.9	89.4	97.3	87.9	94.6
Percentage seeking treatment for STD* (among those who reported having either genital discharge or genital ulcers)	71.1	86.1	71.0	95.1	59.6	81.7	92.8	96.4	70.3	78.2	70.9	82.4
Percentage obtained/ received medicines for STD (among those who sought treatment)		91.4		75.9		92.9		97.1		94.9		93.5
Percentage reported completely cured (among those who received medicines)		83.9		100.0		80.1		85.6		81.0		82.2
Percentage met with any person talking about unprotected sex and danger of STD or HIV/ AIDS at the site during last 6 months		83.6		85.0		78.3		81.0		78.2		79.8
Percentage witnessed any BCC event on HIV/AIDS		74.6		80.8		71.7		61.9		58.5		65.7

Male Migrant Workers[28]

Indicators	Chhattisgarh		Jharkhand		Rajasthan		Uttar Pradesh		ALL (weighted)[29]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
N[30]	***1496***	***562***	***1500***	***551***	***1500***	***533***	***1514***	***550***	***1500***	***550***
Knowledge[31]										
Percentage knew that consistent Condom use reduces the risk of HIV infection (among those who heard about HIV AIDS)	92.6	89.8	78.2	80.1	93.0	90.4	80.1	92.8	81.7	88.9
Percentage correctly aware (with no incorrect knowledge) of all 5 ways of HIV transmission[32] (among those who heard about HIV AIDS)	0.1	0.2	0.1	1.3	0.0	0.9	0.0	1.0	0.0	0.9
Percentage rejecting at least two misconceptions about reducing the risk of HIV infection (among those who heard about HIV AIDS)	49.1	74.1	21.8	85.9	17.4	76.1	64.8	90.9	48.0	85.1
Behavior										
Number of persons screened in 2006 BSS		983		717		950		711		***786***
N	***535***	***562***	***294***	***551***	***519***	***533***	***358***	***550***	***391***	***550***
Percentage had sex either with CSW or En - route CSW or non regular non commercial partner in last 12 months[33]	35.8	57.2	19.6	76.8	34.6	56.1	23.7	77.3	26.0	71.2
N	***535***	***562***	***294***	***551***	***519***	***533***	***358***	***550***	***391***	***550***
Condom use in Last Sex -										
1. With any type of partner	38.0	46.2	7.8	54.2	21.8	74.3	23.4	51.7	22.0	54.3
2. With regular commercial partner	77.7	86.6	40.0	60.7	26.6	89.1	89.5	67.1	68.3	71.4
3. With non-regular commercial partner	76.8	79.5	33.3	72.1	63.2	75.2	58.8	61.1	57.3	68.6
4. With regular non commercial partner	15.6	38.8	11.1	65.4	31.1	67.1	19.3	51.9	20.6	55.1
5. With non regular non commercial partner	41.7	24.9	0.0	0.0	7.9	80.4	0.0	49.0	4.2	37.0
6. With a non-marital, non-cohabiting partner[34]	74.0	80.2	24.2	63.4	39.7	85.7	73.2	63.6	61.0	69.0

[28] The full questionnaire for 2006 BSS was conducted among those who are at risk of acquiring HIV AIDS after initial screening questions
[29] Total sites in each state are used as weights
[30] In 2006 BSS sample include only those who were found at risk
[31] The endline figure for these indicators are based on those who had sex with non marital and non cohabiting partners during last 12 months
[32] Five ways of HIV transmission - Sex with multiple partner or heterosexual acts; sex with infected person; homosexual or other form of sex; infected needles; infected blood
[33] This has been used as screening question in 2006 BSS to determine a respondent about the risk status. The percentage in 2006 BSS has been calculated based on the total number of respondents screened during the survey
[34] Those who had sex either with regular commercial partner, non-regular commercial partner or with non regular non commercial partner

Indicators	Chhattisgarh		Jharkhand		Rajasthan		Uttar Pradesh		ALL (weighted)[29]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
Self Reporting of STD Symptoms										
Percentage suffer from -										
- Genital Discharge	13.2	5.6	4.7	10.2	4.5	18.7	4.9	5.0	5.2	8.1
- Genital ulcers/sores	13.0	7.8	5.2	12.5	13.3	21.1	5.3	3.2	7.4	8.5
Percentage had sex with any partner while suffering from STDs	26.0	37.4	32.3	57.2	32.4	57.0	31.1	38.5	30.5	45.3
Perception of Risk[6]										
Perception of contracting STDs	11.1	19.0	20.2	17.2	NA	18.4	18.5	31.5	16.4	24.3
Perception of contracting HIV/AIDS	18.9	32.4	6.5	27.4	19.7	40.1	11.3	41.1	12.9	36.2
Others[6]										
Time of Condom Use (Before first penetration)	92.4	91.3	87.5	92.2	89.1	88.3	98.5	95.6	92.8	93.1
Male to Male Sexual behavior	9.7	3.5	1.6	3.1	2.7	10.1	6.7	5.9	5.4	5.4
Median age at sexual debut	18.0	18.0	17.0	18.0	18.0	18.0	18.0	17.0	17.5	17.5
Process Indicators (among those who are at risk)										
Percentage heard about STD[6]	67.9	80.2	57.4	89.7	58.5	82.0	60.4	80.9	58.8	83.1
Percentage seeking treatment for STD[6] (among those who reported having either genital discharge or genital ulcers)	73.3	79.2	70.0	89.3	87.0	86.8	67.4	84.4	70.8	85.1
Percentage obtained medicines for STD (among those who sought treatment)		95.3		99.7		95.2		84.2		91.2
Percentage reported completely cured (among those who received medicines)		94.2		90.6		95.5		86.2		89.8
Percentage knew any persons from neighborhood talking about unprotected sex and danger of STD or HIV/AIDS		64.8		74.3		63.5		68.5		68.7
Percentage witnessed any BCC event on HIV/AIDS		42.0		77.8		51.3		61.4		61.1

Truckers[35]

Indicators	Chhattisgarh		Delhi		Jharkhand		Rajasthan		Uttar Pradesh		ALL (weighted)[36]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
N[37]	***1516***	***489***	***1552***	***555***	***1500***	***489***	***1500***	***528***	***1505***	***485***	***1500***	***493***
Knowledge[38]												
Percentage knew that consistent Condom use reduces the risk of HIV infection (among those who heard about HIV AIDS)	92.7	93.3	94.4	97.5	88.4	90.0	89.8	95.3	87.3	93.7	88.7	92.8
Percentage correctly aware (with no incorrect knowledge) of all 5 ways of HIV transmission[39] (among those who heard about HIV AIDS)	0.3	0.0	0.6	2.0	0.0	1.0	0.1	2.6	0.1	1.1	0.1	1.0
Percentage rejecting at least two misconceptions about reducing the risk of HIV infection (among those who heard about HIV AIDS)	66.6	81.1	78.9	88.8	19.6	75.8	15.1	81.6	67.4	85.6	50.2	81.4
Behavior												
Number of persons screened in 2006 BSS		1056		1801		703		996		692		1184
N	***636***	***489***	***748***	***555***	***475***	***489***	***717***	***528***	***612***	***485***	***591***	***493***
Percentage had sex either with CSW or En - route CSW or non regular non commercial partner in last 12 months[40]	42.0	46.3	48.2	30.8	31.7	69.5	47.8	53.0	40.7	70.1	39.3	62.1
N	***636***	***489***	***748***	***555***	***475***	***489***	***717***	***528***	***612***	***485***	***591***	***493***
Condom use in Last Sex -												
1. With any type of partner	43.3	57.4	37.3	84.5	17.0	66.2	23.6	70.5	32.3	68.8	29.2	66.2
2. With regular commercial partner	73.6	86.0	79.3	93.8	66.7	84.6	73.0	90.1	74.7	87.0	72.4	86.6
3. With non-regular commercial partner	80.8	86.1	77.9	96.1	43.2	75.1	68.8	80.1	54.9	81.4	57.1	80.8
4. With regular non commercial partner	16.3	53.4	37.5	35.3	21.0	45.8	20.6	74.7	27.5	85.0	23.7	64.1
5. With non regular non commercial partner	60.0	59.4	20.0	55.0	5.9	30.1	12.7	63.7	22.2	1.7	22.5	30.2
6. With a non-marital, non-cohabiting partner[41]	78.0	83.4	78.3	94.3	44.8	81.3	69.8	84.0	64.2	82.1	62.0	82.7

[35] The full questionnaire for 2006 BSS was conducted among those who are at risk of acquiring HIV AIDS after initial screening questions
[36] Total sites in each state are used as weights
[37] In 2006 BSS sample include only those who were found at risk
[38] The endline figure for these indicators are based on those who had sex with non marital and non cohabiting partners during last 12 months
[39] Five ways of HIV transmission - Sex with multiple partner or heterosexual acts; sex with infected person; homosexual or other form of sex; infected needles; infected blood
[40] This has been used as screening question in 2006 BSS to determine a respondent about the risk status. The percentage in 2006 BSS has been calculated based on the total number of respondents screened during the survey
[41] Those who had sex either with regular commercial partner, non-regular commercial partner or with non regular non commercial partner

Indicators	Chhattisgarh		Delhi		Jharkhand		Rajasthan		Uttar Pradesh		ALL (weighted)[36]	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
Self Reporting of STD Symptoms												
Percentage Suffer from -												
- Genital Discharge	11.2	4.3	7.3	2.9	5.8	8.4	7.1	16.7	6.2	4.9	6.9	7.0
- Genital ulcers/sores	13.5	9.7	8.4	2.5	2.9	13.2	7.0	21.3	8.8	5.0	7.8	10.1
Percentage had sex with any partner while suffering from STDs	27.1	42.0	31.3	27.3	36.4	47.4	36.5	51.6	39.2	31.9	36.4	40.6
Perception of Risk[13]												
Perception of contracting STDs	11.0	23.8	17.2	27.6	14.2	15.8	11.1	23.6	9.5	38.2	11.2	26.6
Perception of contracting HIV/AIDS	21.1	30.8	31.1	45.2	12.7	29.6	23.5	37.4	19.1	39.3	18.3	34.5
Others[13]												
Time of Condom Use (Before first penetration)	97.0	97.2	98.8	99.3	76.3	89.9	95.7	95.0	98.0	93.6	92.0	93.5
Male to Male Sexual behavior	10.4	4.8	9.9	5.2	4.1	4.5	3.5	8.0	9.2	11.2	7.5	7.3
Median age at sexual debut	18.0	18.8	18.0	18.0	18.0	19.0	18.0	18.0	18.0	18.0	18.0	18.5
Process Indicators (among those who are at risk)												
Percentage heard about STD[13]	71.9	82.7	89.3	82.9	79.7	83.9	75.9	91.1	77.7	84.8	77.4	84.7
Percentage seeking treatment for STD[13] (among those who reported having either genital discharge or genital ulcers)	83.9	86.2	70.7	72.7	69.5	89.9	80.9	86.5	68.2	87.7	72	87.5
Percentage obtained/ received medicines for STD (among those who sought treatment)		99.1		93.8		98.3		97.6		98.5		98.3
Percentage reported completely cured (among those who received medicines)		92.5		100.0		93.4		90.8		87.0		90.8
Percentage met with any person talking about unprotected sex and danger of STD or HIV/ AIDS at the site during last 6 months		59.8		70.1		65.8		61.9		53.0		59.7
Percentage witnessed any BCC event on HIV/AIDS		52.3		75.1		68.1		52.4		48.1		56.2

Limitations

The BSS methodology has some limitations and therefore the results need to be interpreted with caution. Some of the limitations of BSS are:

- Self reporting of information about sexual behavior by the target population
- Attributing behavior change to prevention intervention
- True level of risk may be under-reported using survey methodology
- True estimates of target population at risk could not be achieved in BSS 2006 due to introduction of the screening questionnaire.
- The estimates related to FSWs in Rajasthan represents mainly one city (Jodhpur) in which accounts for majority of the FSWs in the demonstration area in this city

Chayan Project: Urban Implementation Partners

State: Uttar Pradesh

Sl. No	Partner NGO/Chief Functionary	Address with contact number	Target Group
1	Bard K.K. Singh	E-134, 1st Floor, Sector 27, Noida, UP – 201301 Phone (020 – 2549296, 09810088521)	• Ghaziabad District Migrant Labourer • Ghaziabad District, Youth
2	Shah Joginder Nath Makkar	2/5136, Krishna Nagar, Ganga Mandir Marg, Dev Nagar, New Delhi – 5. Phone (011 – 25766221)	• Ghaziabad District FSWs • Ghaziabad District Truckers
3	Beti Foundation Sehba Hussain	B-842, Sector C, H Road, Mahanagar, Lucknow – 6 Phone (0522 – 2334878)	• Lucknow Youth
4	Pani Bharat Bhusan	LIG – 7, Sector G, Jankipuram, Lucknow - 1 (Phone – 9451204496)	• Lucknow Truckers • Lucknow FSWs
5	Dr. Shambhu Nath Singh Research Foundation Rajiv Kr. Singh	C 14/160, B-2, Dr. Sambhunath Singh Marg, Sonia, Varanasi, UP (Phone – 0542 – 2414111, 241461)	• Lucknow Migrant Laborer
6	KGVS Dr. G.C. Katiyar	Vill & P.O. Bhainsau, Block – Shivrajpur, Kanpur (Nagar), UP – 1 (Phone – 9415486360)	• Sitapur Truckers/ FSWs • Sitapur Youth • Sitapur Migrants • Kanpur FSWs
7	Adarsh Seva Samiti, Dr. Sita Ram Sharma	326/1, Saket Colony, Muzaffarnagar, UP (Phone – 011 22598499)	• Agra FSWs • Agra Youth
8	Action for Women & Rural Development, U.C. Pandey	127/299, W Block, Keshav Nagar, Kanpur (Phone – 9415041774)	• Agra Migrant Laborer • Agra Truckers • Allahabad FSWs • Allahabad Migrants
9	Jan Kalyan Mahasamiti, B. P. Pandey	2. Gautam Nagar, ITI Road, Fatehpur (Phone – 941541774)	• Allahabad Migrant Laborer • Allahabad Truckers • Kanpur Truckers
10	Guria, Ajit Singh	S-8/395, Kgajuri Colony, Varanasi (Phone – 0542 – 3097794, 9335580587)	• Varanasi FSWs • Varanasi Youth
11	Manav Sewa Kendra, Jagat Narain	C-33/45, C-27, Chitturpur, Varanasi (Phone – 0542 – 2221238/941530862)	• Varanasi Migrant Laborer • Varanasi Truckers
12	Sakhi Kendra, Neelam Chaturvedi	7, HIG, KDA Colony, P. A. C. Road, Shyam Nagar, Kanpur (Phone – 052 – 2422478, 9415535329)	• Kanpur Youth
13	Amin Welfare Trust, Ivan Robert Luther	C/o Chaudhary Ehsam, Kareem Hospital, Jajmau Road, Kanpur, UP	• Kanpur, Migrants

State: Jharkhand

Sl. No	Partner NGO	Address with contact number	Target Group
14	Manav Seva Sansthan (MSS)	LIG – 1 – 198, Vikas Nagar, Via FCI factory, Gorakhpur Pin – 273007 Ph: (91-551) 2261397, 2261398, Fax : 0551 – 2260592	• Ranchi Migrant Laborer
15	Alternative for India Development (AID)	Albert Compound, Pathal Kudwa, Purulia Road, Ranchi – 834001 Ph : 0651-2301963	• Ranchi Truckers
16	Basti Vikas Manch (BVM)	Ph : 94311 69692	• Ranchi FSWs
17	Gram Praudyogik Vikas Sansthan (GPVS)	129 – Co-operative Colony, First Floor, Bokaro Steel City, Bokaro Ph: +91-06436-222431 (O), Cell : +91-612-3112518/ 94310-72012	• Bokaro and Dhanbad Migrant Laborer/ Truckers/FSW/Youth
18	Young Men's Christian Association	Johannessen Building, Old Hazaribagh Road, Ranchi – 834001 Ph : 0651-2351720	• Ranchi Youth
19	Parivar Kalyan Sansthan		• Jamshedpur Migrant Laborer/Truckers/ FSW/Youth

State: Chhattisgarh

Sl. No	Partner NGO	Address with contact number	Target Group
20	IMME	**Head Office:** CJ-49, Salt Lake, Kolkata-700091, 033-32503600, TeleFax:-033-23372158 **Branch Office:** MIG-II/3, BDA Quarters, Nutan Enclave, Sarkanda, Bilaspur-495006, Ph. No. 07752-254465, Mobile No. 9826154464	• **Bilaspur** Migrant Laborer/Truckers/ FSWs/Youth • **Raipur** Migrant Laborer/Truckers/ FSWs/Youth
21	BMSS	Quarter No. 9/H, Street-1, Zone-III, Khursipar, Bhilai , District- Durg (Chhattisgarh) Mobile No. : 98271-17467	• **Korba** Migrant Laborer/Truckers/ FSW/Youth • **Durg** Migrant Laborer/Truckers/FSWs/ Youth

State: Delhi

Sl. No	Partner NGO	Address with contact number	Target Group
22	DESH (Deepam Educational Society for Health)	Dr. Saraswathi Sankaran, D.S.S. Ph.D. Deepam Educational Society for Health 3/655 – B, Kuppam Road Kaveri Nagar, Kottivakkam Chennai – 600 041	• Youth
23	Apollo Consumer & Welfare Trust	Ms. Harshita Pandey Apollo Dealers & Consumers Welfare Trust C/o Apollo Tyres Ltd., Sector 32 7, Institutional Area, Gurgaon – 122 001	• Truckers
24	Anchal Charitable Trust	Mr. Sanjeev Sheel Anchal Charitable Trust, ACT Flat No. 167 – A, Mansarovar Park, Shahdara, Delhi – 110032	• FSWs

State: Rajasthan

Sl. No	Partner NGO	Address with contact number	Target Group
25	Dr. Bhim Rao Ambedkar Shikshan Samiti	Mr. B. R. Meghwal, Secretary, K – 4 – Jyoti Nagar, Chandana Bhakar, Jodhpur	• Jodhpur Migrant Laborer
26	Jagruk Mahila Vikas Samiti	Rai Ka Bagh, Paota, Jodhpur	• Jodhpur FSWs
27	Jodhpur Goods Transport Association	72 Transport Nagar, Basni, Jodhpur	• Jodhpur Truckers
28	Jodhpur Adult Education Association	Mr. Vimal Raj Singhvi, President, 44 – Mahavir Nagar, Residency road, Jodhpur	• Jodhpur Youth
29	CUTS	CUTS – CHD, Rawala Senti, Chittorgarh – 312025	• Bhilwara Youth
30	Garib Nawaz Mahila Evam Bal Kalyan Samiti	Mrs. Shagfta Khan, Secretary, Hamida Cottage, Ander Kot, Ajmer	• Bhilwara FSWs/Truckers/Migrant Laborer
31	Yuva Bharat Sewa Sansthan	Mr. Dinesh Pandey, Secretary, C – 184, Gandhi Colony, Pawanpuri, Bikaner – 334003	• Bikaner FSWs/Truckers/Migrant Labourer
32	Sewa Mandir	Ms. Neelima Khaitan, CEO, Old Fatehpura, Udaipur	• Udaipur Youth/Migrant Laborer
33	Astitva Sansthan	Ms. Anjum Sayeed, Director, 33 – Nayapura, Delhi Gate, Udaipur	• Udaipur Truckers

Acronyms and Non-english Terms Used

AWC	Anganwadi Center
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
CB	Capacity Building
CBO	Community-based Organization
Chayan	Hindi word, means Choices
CG	Chhattisgarh
CSG	Community Stakeholder Group
CSW	Commercial Sex Worker (female)
DHFW	Department of Health and Family Welfare
DLAC	District Level Advisory Committee
DS	Demonstration Site
DUDA	District Urban Development Agency
DWCD	Department of Women and Child Development
FE	Final Evaluation
FHAC	Family Health Awareness Campaign
FP	Family Planning
FSW	Female Sex Worker
GoI	Government of India
HLL	Hindustan Latex Limited
HMIS	Health Management Information System
HRBG	High Risk Behavior Group
HSP	Health Service Provider
ICDS	Integrated Child Development Scheme
INHP	Integrated Nutrition and Health Project
ISOFI	Inner Spaces and Outer Faces Initiative
JH	Jharkhand
LSE	Life Skills Education
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
MHRD	Ministry of Human Resource Development
MTR	Mid Term Review
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NASHA	Needs Assessment and Stakeholder Analysis
NCC	National Cadet Corps
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
NSS	National Service Scheme
NYK	Nehru Yuva Kendra
ORW	Outreach Worker
PE	Peer Educator
PHC	Primary Health Center
PHN	Population, Health & Nutrition
PIP	Project Implementation Plan
PLA	Participatory Learning and Action
PMP	Private Medical Practitioner
PRI	Panchayati Raj Institution
PSI	Population Service International
RA	Rajasthan
RACHNA	Reproductive and Child Health, Nutrition and HIV/AIDS Program
RCH	Reproductive and Child Health (Program)
RMP	Registered Medical Practitioner
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SAIL	Steel Authority of India Limited
SM	Social Marketing
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TI	Targeted Intervention
UP	Uttar Pradesh
VCTC	Voluntary Counseling and Testing Center
YRC	Youth Resource Center

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CARE-India, August 2008

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About RACHNA

Two major projects of the Reproductive and Child Health, Nutrition and HIV/AIDS (RACHNA) program of CARE-India completed five years of work supported by funds from USAID in late 2006. The second phase of Integrated Nutrition and Health Project (INHP-II) was aimed at helping reduce child malnutrition and mortality. The rural component of the *Chayan* project primarily addressed the unmet need for spacing methods, while its urban component attempted to reduce HIV transmission among at-risk groups. Together, the projects covered 78 districts and 22 cities, spread over 10 states, and worked closely with key national programs and a spectrum of different partners. This series of working papers documents the results and lessons from these five years.

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