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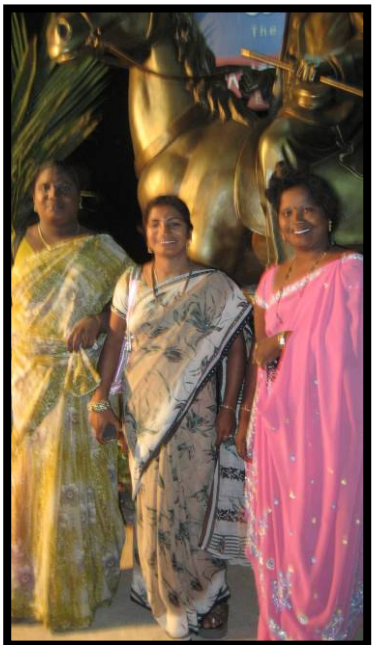
Brief abstract (description of project)	Since June 2004, CARE India has been implementing a HIV/AIDS prevention capacity building initiative entitled SAKSHAM or 'Strengthening Awareness, Knowledge and Skill for HIV/AIDS Management. Capacity building in CARE's Community Led Structural Interventions (CLSI) model is SAKSHAM's critical contribution to Avahan's mandate.
Comment	

Final Evaluation
SAKSHAM Project

Report to
CARE INDIA



On 15 May, 2009

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Abbreviations

ADMHO	Additional. District Medical and Health Officer
ANC	Antenatal Clinic
AP	Andhra Pradesh
APSACS	Andhra Pradesh State AIDS Control Society
ART	Anti-retroviral Treatment
CBO	Community Based Organization
CCC	Community Care Center
CLSI	Community Led Structural Intervention
GMS	Godavari Mahila Samakhya
ICTC	Integrated Counseling and Testing Center
IAI	India AIDS Initiative
IEC	Information Education and Communication
KP	Key Population
MIS	Management Information System
NACO	National AIDS Control Organization
NACP3	National AIDS Control Program
NGO	Non-governmental Organization
ORW	Outreach Worker
PE	Peer Educator
STI	Sexually Transmitted Infection
SCA	Social Change Agent
TA	Technical Assistance
TI	Targeted Intervention
ICTC	Integrated Counseling and Testing Center
VCT	Voluntary Counseling & Testing

Executive Summary

Since June 2004, CARE India has been implementing a HIV/AIDS prevention capacity building initiative entitled SAKSHAM or 'Strengthening Awareness, Knowledge and Skill for HIV/AIDS Management. Capacity building in CARE's Community Led Structural Interventions (CLSI) model is SAKSHAM's critical contribution to Avahan's mandate. SAKSHAM Final Evaluation focuses on **three objectives** which aim to answer the following questions:

1. Has SAKSHAM reduced HIV vulnerabilities and enhanced rights?
2. Is Nari Saksham prepared to manage project implementation?
3. Does the learning site in Rajahmundhry have the capacity to serve as the center of a learning strategy?

The evaluation was conducted by a four-person external team with expertise in community mobilization, TIs, epidemiology and CBO development. The **methodology** combined quantitative analysis (from project and CMIS reports) and qualitative analysis (from observations, focus group discussions and in-depth interviews).

The evaluation **findings** represent analysis of themes and patterns found in the SAKSHAM implementation component across Nari Saksham, six of the 11 federated CBOs and the SAKSHAM learning component across four immersion participant groups and the learning site itself.

SAKSHAM has reduced HIV Vulnerabilities and enhanced rights through achievements made by enabling sex workers' environment, community mobilization and service utilization. Saksham has a well articulated multi-level response strategy to address violence. The team was impressed with well-attended and operational six drop in centers (DICs) observed. All six CBOs visited appeared vibrant, committed and well represented. Structural intervention initiatives receive support from CARE staff on management, accounting and administrative responsibilities. As observed in the clinic records, about 50% of sex workers are accessing functional STI services. This is up from 15 to 20%, in the first three years. According to interviews and minutes from Arogya Brundum (health committee), 99% of clinic attendees are satisfied with services. Linkages to the health care system have improved dramatically over the past two years. The health care providers reported that linkages to primary health centers in the area are quite good.

Despite progress made over the past two years, challenges exist. Low HIV testing and follow-up of HIV services exist. Arogya Brundam needs to do more to follow up cases and their contacts for STIs. While a supportive CBO environment is evident, discrimination among sex workers, in relation to positive status continues to prevail. More needs to be done to strengthen CBOs' skills in adaptive management, financial accountability, strategic analysis, planning, and sustainability. Moreover, SAKSHAM must continue to stay on course, as demonstrated in the past two years, to deliver targeted interventions to continue improving HIV outcomes.

Nari Saksham does not seem to be prepared to manage project implementation at this time. Nari Saksham is a vibrant federation of 11 committed CBOs with 1205 registered

members. It has a history of supporting effective advocacy initiatives through institutionalized mechanisms such as the CIT, cultivated over the past five years. Nari Saksham faces key institutional challenges which need to be overcome before they can assume overall program responsibilities. Most critical is related to the executive committee's limited capacities to lead.

The learning site in Rajahmundhry has the capacity to serve as the center of a learning strategy if they receive strategic guidance and technical capacity in key areas. The learning site runs two (flexible) learning curriculum/circuits which are adapted to needs and expectations of participants. With a strong understanding of CLSI (in theory and practice) community consultants appeared to have clear concepts of their roles as both trainers and active Nari Saksham members. Six well designed toolkits were developed. The immersion program participants gave extraordinary accolades to SAKSHAM for their immersion experiences. In all cases, substantive learning, drawn directly from the field, transformed their programs.

A few learning site challenges were also apparent. The separation of the learning and demonstration sites impedes prospective learning opportunities through a capacity-building program that is imbedded in the field. More needs to be done to strengthen research, documentation and materials development, to progress SAKSHAM's learning component so that it is more strategic and focused on key CLSI features.

Recommendations

1. Adaptive Management, leadership and oversight
2. Vision, planning and sustainability focused on prevention
3. Strengthening programs through micro-finance and systematic advocacy strategies
4. Consider combining learning and implementation sites so that dynamic cross-learning between the immersion participants and the SAKSHAM community takes
5. Develop learning strategy
6. Conduct in-depth analysis of key learning areas to better understand CLSI and its impact on health outcomes. Identify focus areas to develop deeper understandings
7. Develop step-by-step guidelines on participatory process documentation using a range of media sources. A dissemination strategy should be developed early on.

1. Background

Since June 2004, CARE India has been implementing a HIV/AIDS prevention capacity building initiative entitled SAKSHAM or 'Strengthening Awareness, Knowledge and Skill for HIV/AIDS Management. While CARE's role in implementing targeted Interventions (TIs) can not be underestimated, capacity building in CARE's Community Led Structural Interventions (CLSI) model is SAKSHAM's critical contribution to Avahan's mandate. The heart of the SAKSHAM model, therefore, aims to address (social, political and economic) structural inequities faced by female sex workers to reduce HIV vulnerabilities and enhance their rights. The key elements in SAKSHAMs approach consist of three overlapping components-- enabling environment, community mobilization and access and utilization of services, as described in Annex I.

Andhra Pradesh is a priority state for HIV/AIDS control, with 23 out of 23 districts classified as high prevalence (Cat A) by NACO. The Rajahmundry area consists of peri-urban and rural districts and home to many traditional sex workers and a thriving sex industry. East Godavari has a complicated mosaic of sex work patterns and accounts for a high prevalence of HIV-- 15.6% prevalence among female sex workers in targeted interventions (TIs) and 1.88% in ANCs in 2007[1]. High mobility, home-based sex workers operating in secret, women soliciting on streets and highways, traditional sex workers and brothel-based sex workers create a scenario of high HIV/AIDS vulnerability among extremely difficult to reach population groups.

HLFPPT conducted a mapping exercise, in 2007 in which they found approximately 1,150 FSWs in ten mandals of East Godavari district, in AP-- SAKSHAM's operational. Currently, HIV interventions are being provided to around 1,700 FSWs.

SAKSHAM is now nearing the end of its current phase. Avahan funding for a second learning phase is awaiting approval. Avahan funding for implementation is being discussed so that support for HIV/AIDS services and CBOs will continue with support likely to be handed over to APSACS and/or other Avahan partners.

SAKSHAM Objectives

Supported by Avahan, through the Bill and Melinda Gates Foundation, SAKSHAM started with three main objectives, which were revised in 2007.

Goal: "By 2009, India AIDS Initiative (IAI) partners and State AIDS Control Societies (SACS) will be demonstrating increased leadership and capacity for effective HIV/STI prevention in six IAI states".

Objectives include:

1. Innovative strategies for reaching female sex workers with structural and targeted interventions for HIV/STI prevention will be successfully demonstrated in two project sites; key lessons will be applied by other implementing agencies;

[1] Andhra Pradesh Annual Action Plan 2009-10, APSACS, 2009 available at http://www.apsacs.org/AAP-2009-10.pdf

2. IAI partners will have initiated implementation of high quality structural interventions in HIV/STI prevention in six Indian states; and
3. Partnering with National AIDS Control Organization (NACO) and State AIDS Control Societies (SACS)

2. Evaluation Purpose, Objectives and Limitations

The **purpose** of this evaluation aims to:
1) promote cross-learning as the findings will capture the strengths of community mobilization strategies which reduce HIV vulnerability; 2) provide a fresh perspective from a variety of external perspectives, experiences and expertise; and, 3) inform decisions and design of follow-on projects in Avahan's second phase. To this end, the SAKSHAM Final Evaluation focuses on **three objectives** which aim to answer the following questions:
Has SAKSHAM reduced HIV vulnerabilities and enhanced rights?
Is Nari Saksham prepared to manage project implementation?
Does the learning site in Rajahmundhry have the capacity to serve as the center of a learning strategy?

An **evaluation framework and tools** were developed to focus the evaluation on these questions, as seen in Annex 2. Given the time and scope, the evaluation has a number of **limitations**. Specifically, it was not able to respond to concerns related to over-arching structural issues such as the design and redesign of decision-making bodies across CBOs, Nari Saksham, SAKSHAM Managers and current wing positions. Similarly, it was not able to obtain depth in key areas related to the CIT, learning strategies, and innovative initiatives such as the positive sex work network. Rigorous applied inquiry using qualitative and participatory tools are necessary to explore these areas to this end, presumably during Phase II.

3. Evaluation Methodology

The evaluation team consisted of an external team leader (Veronica Magar), a community member from Andhra Pradesh (Jayamma Bandari), APSACS representative (Nirupama Rao) and a medical epidemiologist and CDC representative (Dr. Dipanjan Roy). The review took place between 6 April to 15 May, 2009; the Evaluation Schedule is outlined in Annex 3.

The evaluation methodology combined quantitative analysis (from project and CMIS reports) and qualitative analysis (from observations, focus group discussions and in-depth interviews). Specific data sources include:

- desk review of project reports;
- discussions with the CARE team members;
- direct observation and interaction with staff and participants in the implementation site (in East Godavari);
- Interactions with the Nari Saksham governing body, representatives with CLSI initiative and CBOs;

- meetings and observations of government and other partners at APSACS and medical facilities;
- meetings with learning site staff; and,
- meetings with immersion participants and partners from Delhi, North East and Andhra Pradesh.

4. Findings

The evaluation findings represent analysis of data collected by the team based on themes and patterns found in the SAKSHAM implementation component across Nari Saksham, six[2] of the 11 federated CBOs and the SAKSHAM learning component across four immersion participant groups (Delhi SACS partners, Orchid, Lepra Society, Kottapeta Mahila Mandali)and the learning site itself. CARE India's relative contribution, from Rajahmundry and Delhi, was analyzed vis-à-vis these CBOs and SAKSHAM special CLSI initiatives. The quantitative findings provide analysis of the community-based MIS with a focus on frequencies and trends which provide a historical understanding of changes over the past five years. The findings answer the three questions identified by the evaluation objectives and inform recommendations listed in the subsequent section.

4.1 Has SAKSHAM Reduced HIV Vulnerabilities and Enhanced Rights?

Over the last four years, four separate cross sectional studies were undertaken to examine associations between community mobilization and health outcomes. Yale used a structural intervention framework, in two follow-up studies (2006, 2007), to analyze associations between condom use and empowerment. In 2007, Population Council conducted an exploratory study to assess female sex workers' sexual and reproductive health needs. In 2008, CARE commissioned a study to explore the links between community mobilization and health outcomes. The three studies conducted by Yale and Population Council were external studies. Some of the indicators correspond with one another and are able to demonstrate a change over time.

As seen in the table in Annex 4, the findings show changes across seven key indicators. For example, in 2006 86% of SAKSHAM participants reported that they sex workers deserve rights like any other worker. In 2008, this was increased to 96%. Similarly, only 35% of SAKSHAM participants reported that 'other sex workers would support them in case they were sick,' compared to 85% in 2008. STI treatment seeking behavior in the SAKSHAM clinic increased from 10% to 85% over last three years.

By and large, these trends show progressive improvements that reflect enhanced program coverage and health outcomes related to community mobilization. Perhaps the most imperative finding relates to the Yale study which showed that the interaction between program exposure and collective agency was significant. Specifically, among

[2] Chaitanya (brothel-based); Divya Mahila (traditional Kalavanthalu – lineage of temple courtesans in Andhra Pradesh ref. AIDS Sutra); Satya Priya (home- and highway-based); Arunodaya (home-based and traditional Kalavanthalu); Asha Kiranalu (home- and street-based), Adarsa (agrarian and home-based) Naari SAKSHAM (confederation of 10 CBOs)

respondents who reported both program exposure and high levels of collective agency were 2.5 times more likely than other sex workers to use condoms consistently[3].

The following sections demonstrate the extent to which these findings are supported through a review of processes and outcomes observed in Rajamundary and among partners. In addition to direct implementation which led to the above findings, it also it illustrates findings in relation to two additional evaluation questions related to Nari Saksham preparedness to assume program responsibilities and strength of the learning site. Annex five presents a list of recommendations made in the MTR accompanied by changes accomplished over the past two years in response to those recommendations. Many of the items are discussed in more depth throughout this evaluation report.

4.1.1 Enabling Environment Achievements

Well articulated multi-level response strategy to address violence

All six CBOs reported that police and hooligan violence dramatically reduced as a result of relationships built with police, understanding and applying the law through trained local lawyers, and a well prepared Crisis Intervention Team (CIT) response. Most members from the six CBOs articulated the various laws affecting them such as the ITPA act, public nuisance laws, implying that CARE provided adequate advocacy training. According to reports from the CIT, the CIT responded to 100% of violence incidents - perpetrated by police, rowdies, partners - within 24 hours. While this indicator may not capture all the violence cases in the community, since some may go unreported, it does indicate the level of enthusiasm and commitment that exists within CIT.

According to respondents, 90% of police stations are covered within 10 mandals. The CIT is composed of community members (60%) and external members (40%) such as lawyers, human rights activists, state human rights council members, youth leaders, doctor, political leaders and Dalit Mahasabha representatives. Members are not only clear about their roles, but also demonstrated commitment and passion to CIT responsibilities.

There are now 28 pending cases related to ITPA, public nuisance or obscenity/illegal soliciting. Nari Saksham won one case in which police charged eight sex workers -under the immoral trafficking and prevention act (ITPA) - with illegal trafficking. Another noteworthy case against a police superintendent was submitted to the Human Rights Commission. This superintendent illegally detained sex workers, beat them after which they were hospitalized. This medico-legal case was submitted to the human rights commission and is pending.

Unlike many CBOs across India, Nari Saksham has a policy of not settling cases that generally result in police-bribes. While there appeared to have been some exceptions to this policy, by and large, most cases are dealt with by the support of local lawyers. Avoiding "settlement" of cases demonstrates exemplary fortitude and courage since

[3] Blankenship, Kim et al, Power, community mobilization, and condom use practices among females sex workers in Andhra Pradesh, India *AIDS* 2008, 22 (suppl. 5)

compromising with police-demands allows community members opportunities to forgo additional harassment and pressure exacted by the police. However, little is known about the impact of such an approach in relation to sustainability, social and economic benefits and costs. More research is required to this end.

In terms of anti-trafficking work, Nari Saksham has a dual policy that does not allow girls under the age of 18 enter into the sex industry and prohibits coercion in sex work of any age. A self regulatory board (SRB) was developed at the district level, as part of the CIT mandate, to monitor and respond to underage sex work. The SRB works with police, brothel madams, community members and other stakeholders to end underage sex work. Approximately 27 such cases were addressed and resolved by placing girls in remand homes or repatriating them to their original home.

CIT Challenges: While situations have dramatically improved over the past five years, SAKSHAM CBOs continue to face challenges from stakeholders such as police, temporary husbands/lovers, rowdies and political persons. As in CBOs across India, most of their work focuses on response rather then applying systematic advocacy strategies – by selecting primary and secondary audiences, advocacy messages, messengers and tactics - geared towards prevention.

SAKSHAM has challenged police in countless ways on behalf of sex worker rights. As a consequence, police violence has reduced. There is some indication, however, that despite positive gains local police officials will once again abuse their powers as narrated by a SCA,

Some police they still don't like us. They tell us, "Wait till CARE leaves! You'll see what we'll do to you!!(Sic)

This latent attitude among some police suggests that while continued police persuasion and sensitization is necessary, structural support mechanisms through local, regional and national institutions are critical for sex worker empowerment forces to remain intact. Broad-based movement building - with the women's movement, dalit movement, gay, lesbian, bisexual and transgender (GLBT) movement - is a critical means to this end.

The CIT themselves identified shortcomings based on a need to better understand accounting and management skills. CIT is a subcommittee of Nari Saksham and hence did not focus on building the financial management skills. When asked where they felt they were weak, the CIT members themselves reported that book keeping and managing their team across several CBOs proved to be a challenge. Although it was not part of the CIT mandate, the members felt it was important for them to learn how to raise resources by writing proposals. The enthusiastic and accomplished CIT coordinator stated with confidence:

We have some things to learn, to manage, to raise money... but, we can do it... we will do it!

The team was impressed with the six drop in centers (DICs). Each DIC appeared to be secure, well attended and in active operation demonstrated by photos, paper clippings, information-education-communication (IEC) materials and social maps displayed. Apart from two CBOs, members were able to discuss how the IEC material was used. According to project records and DIC registers, more than 90% of the FSW population accesses the DICs at least monthly. Not surprisingly, 100% of DICs are being managed by community members themselves, under guidance of CARE staff. The management of DICs was handed over to the project staff (under Nari Saksham) in October 2008.

Entitlements received Community members, Nari Saksham (N=1465)

Entitlement	**Number**
CBO Membership	1205
Ration Card	1005
Voter ID	900
SHG membership	700
Bank/post office account	500
Health insurance	907

Over the past two years, SAKSHAM has mobilized resources for community members by supporting their claims to entitlements. For example, voter registration and ration cards allow community members to access a range of entitlements such as food rations. Twelve community members, from Dhavaleswaram, received allotment letters for government land. Most of the community members (907) now have the Arogyasree health insurance card, introduced by government.

SAKSHAM's primary challenge is to ensure that this initiative is scaled such that all community members obtain access to government entitlements with the skills to acquire them.

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4.1.2 Community Mobilization Achievements

The six CBOs visited are vibrant, committed and well represented. Each CBO is registered under the societies' registration act and have members ranging from 120 to 300 per CBOs. All of the CBO office bearers have received capacity building training. They demonstrated effective crisis management skills, advocacy and ability to form and maintain linkages to government services. Community members expressed enthusiasm related to a range of activities such as event-planning, trainings, and community led initiatives such as the community kitchen and the health committee. The executive committees rotate with active representation on CLSI committees. Most of the CBOs maintained and updated up to eight registers for membership, minutes, condom distribution, counseling, clinic visits, visitors, DIC register, property and assets register. Approximately 50-60% of community members are practicing savings, though sometimes it is irregular.

CBOs face challenges which are critical to address in the next transition year. CBO capacity to manage and run day-to-day activities varied. Currently six out of the 11 federated CBOs have bank accounts. Some CBOs demonstrated a lack of understanding of accounting. These CBO members were not clear about financial transactions, including those who had bank accounts. While they understood that 25% of their membership fees went to their apex CBO, they did not know how the money was being spent. According to CARE, details related to financial transactions are explained and hard copies of minutes are sent to the CBOs.Those that had bank

accounts, were sometimes unable to demonstrate proof of transactions in the form of accounting books.

In order to form functional CBOs that are self-sustainable, at least 75% of total community members should be CBO members. According to the completed membership forms, only 60% of the total community members are CBO members. This may be because most community members are difficult to reach since they operate in secret, are based at home and above all majority (80 – 90%) are illiterate. This represents a large challenge to Nari Saksham in the coming years. The elected leaders should continue to receive training in two key modules (CBO management and financial management) annually. Ongoing mentoring, follow up, and literacy training should compliment the trainings. Executive committee members should show demonstration of the learned activities for at least three months.

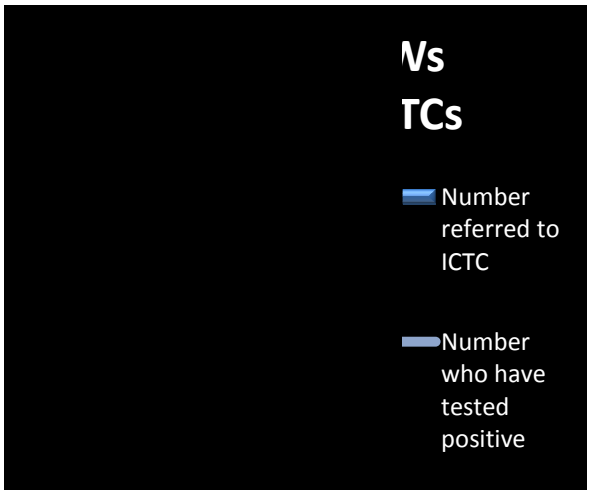
Structural intervention initiatives receive support from CARE staff on management, accounting and administrative responsibilities. For example, trainings on management, accounting and administration for CBO leaders have been provided over the last year by reputed external agencies such as SARDS. CARE should continue obtain such support with external resources. Other areas related to structural interventions may have gained much through external perspectives and technical assistance from experts in the field. Some respondents report that CARE has been working in a silo with less then optimal support from others.

While leadership is one of the CBO strengths, more involvement by community members is called for. In general, only a select number of active leaders are leading most initiatives both within the CBOs and the CLSI initiatives. According to CARE, general body elections are conducted every year. This gives 77 general body members an opportunity to become leaders as they rotate every year. While CBO members were able to articulate their aspirations and vision, many were unable to articulate their future plans, particularly in light of CARE's impending departure. Nari Saksham has not applied for FCRA funding since they have not been in existence for three years. Background work, such as prior approval for foreign grants from the home ministry, has been completed. Raising funds through conduits to route grants may be a challenge in the coming years.

4.1.3 Service Utilization and Access

As observed in the clinic records, about **50% of sex workers are accessing functional STI services**. This is up from 15 to 20%, in the first three years. The denominator has increased from 720 to 1700. While there is an increase in absolute numbers, the benchmark remains the same as year four. The active FSW population (1602 out of 1696) of which 750 or 800 – about half – regularly attend clinic services every three months.

According to interviews and minutes from Arogya Brundum, or health committee, **99% of clinic attendees are satisfied with services**. Only four or five cases, in the past year, provided a poor rating. Dissatisfaction occurs primarily when promised clinics do not take place or there is change in dates.



Linkages to the health care system have improved dramatically over the past two years. These include, for example: Antiretroviral therapy (ART) referral linkages to Tuberculosis Directly Observed Treatment, Short-course (TB DOTS), and integrated counseling and testing centeres (ICTC) have improved dramatically over the last two years. According to clinic records, 80 – 90% clients are accepting referrals to ICTC services. The progress on referrals made as of 31 March, 2009 include: ICTC (1175), ART (N=302), TB DOTS (N=326). Many community members are acting as DOTS providers. As the trend results show, referrals are very good and have improved. Accompanied referrals were not evident, though several community members from the health committee reported that they accompanied referrals regularly. Loss-to-follow up data was not available.

The health care providers interviewed reported that **linkages to primary health centers in the area are quite good**. The linkage to the local medical college GSL is strong. Nari Saksham is involved in the community care center (CCC) with formal referrals which began in January 2009. Nari Saksham office bearers visited this center. Doctors from this medical college attended several sensitization sessions held by Nari SAKSHAM. The medical officer in charge of the CCC is also associate professor of preventive and social medicine. In these capacities he expressed enthusiasm in taking this institutional relationship to the next level. Specifically, he expressed an interest in supporting efforts to make Nari Saksham and CARE as learning sites for all his medical graduates as part of their community medicine instruction.

According to referral registers, referral cards and key informant interviews - from Thummalova, Ravulpalem, and the CARE clinic - about 50% of referred cases are accessing HIV and ICTC services. Data could not be verified as referrals have been strengthened only in the past two years. About 50% of all cases are being followed up by the SCAs

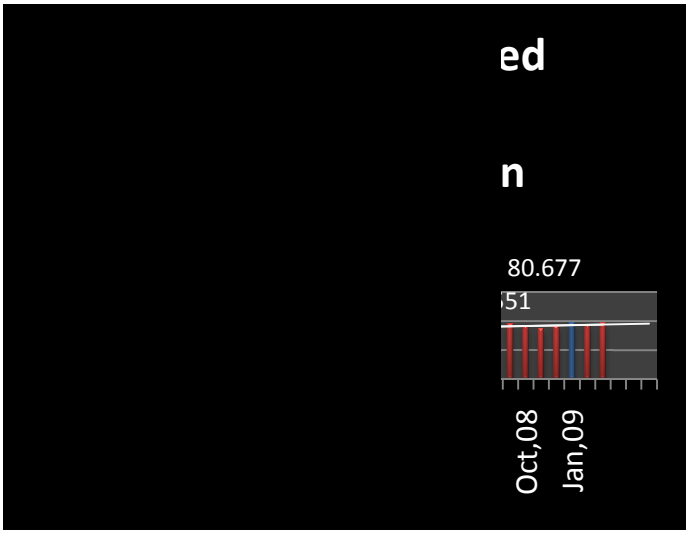
As seen in the training records (verified in Thummalova, Peddapouri and Ravulpalem), 100% of total Social Change Agents (SCAs) were recruited. The visual diaries show that recruited SCAs are performing 100% of the activities.

Sex workers living with HIV/AIDS (SWLHA) is a community led initiative that emerged out of the community members interests themselves. Driven by a need to address positive sex workers' vulnerabilities, SWALA established itself with the aim to advocate for sex worker needs and rights related to care and treatment. This dedicated

group spends much of their time supporting positive sex workers to obtain needed health services, food and treatment. SWLHA members access regular monthly pensions and rice which is provided by the government. There is no positive sex worker enrolled in district level positive networks. This may be, in part, because positive groups discriminate against sex workers as well as internal district level tensions. SWLHA members, however, are part of the state level networks. With minimum support from CARE members have accessed revolving fund opportunities consisting of Rs. 1 Lakh from St. Paul's Trust. Community members contribute a fist full of rice, towards a grain bank, which is distributed to SWLHA members based on a vulnerability analysis conducted by the members themselves.

Some work to prevent stigma is taking place in response to discriminatory behavior. For example, when service providers refuse to admit sex workers for general ailments, the CIT has responded by taking the issue to higher level authorities, including the Additional. District Medical and Health Officer (ADMHO). The ADMHO has stopped discrimination in at least one case.

According to CARE, **SAKSHAM staff developed and implemented a community-based monitoring system** which was later modified by Avahan for the state lead partners. More recently, CARE developed an electronic **MIS system** using Geographic Information System (GIS) technology. This computerized system provides managers with access to community-developed maps and is able to identify shortfalls in service delivery, linkages and follow up within seconds. While innovative and dynamic, it may not be accessible to communities. Some problems related to data sources were not clear. For example, it was not clear from where some figures were compiled and they are not portrayed in the current MIS system. For that reason, staff capacity to document processes with changes over a period of time is not captured.



Condom usage, in the last sexual encounter with non regular partners (average over 28 months) is 87%.

Trends – CARE SAKSHAM and interpretation

Mobile Clinics and their service trends – The project is spread over an area of about 80 kms and a large proportion (about 45%) of sex workers served are home based referred to as "secret sex workers". Others are street-based (20%), brothel-based (19%) and highway-based (16%). During the initial phase of the project, based on the advice from the project management and advisory committee, mobile clinics were started. This increased access of medical services for the sex workers since the governmental system was not treating STIs and HIV/AIDS, at the PHC level, at that time. During the course of time - from 2006 to 2009 - government-supported service delivery systems improved in the areas of STI and HIV detection, treatment and follow up. In the last two years, SAKSHAM has made excellent linkages with government and other local practitioners and tertiary care institutes. As a result, a steadily declining linear trend is observed in the number of mobile clinics held (Chart Mobile clinics above). This trend is consistent with SAKSHAM's sustainability plan. Moreover, it reflects the aspirations of empowered community members to ensure mobile clinics are available. Arogya Brundam, the health arm of SAKSHAM's CLSI, has rationalized the use of this resource based on need and availability. Indeed they played an important role in creating the excellent linkages with PHC, ICTCs, ART and other tertiary care centers.

Flat trends are observed *for symptomatic STI cases*. The graph shows a peak in September 2007, slowly increasing from early 2007; it descreased in early 2009. This finding is in line with trends seen among STI cases in government and private clinics[4], in the Rajahmundry area. Because the clinics became functional in December 2006, data of patients accessing services are captured since that time. STI cases were being treated with private and government linkages before that period, thus data is captured since Dec'05. The 2007-08 rise and fall is a result of rigrous programatic efforts to improve access to services. The decline is due to greater use of government services as a result of government linkages strengthened.

Challenges include:

[4] The data is available from STI studies conducted in AP and presented by Dr Vadrevu Ravi, STI practitioner Kakinada at STI conference, Mumbai 2009.

Condom distribution, which is primarily distributed free-of-cost, is adequate. According to one of the reviewers, community members are given 3 condoms per day. Some of the community members also purchase commercial condoms through social-marketed brands. Also at times they access condoms directly from PHCs or local health centers. This is not surprising given the category of sex workers that are mostly home-based. According to CARE staff, each community member is given condoms as per need. The MIS data provide the number of sexual acts per month. Accordingly, community members receive approximately 3 condoms per sexual act. Though the number of sexual acts may be under-reported, it seems to suggest that an adequate number of condoms is distributed.

Despite recent improvements, the primary weakness of this TI is **low HIV testing and follow-up of HIV services**. These services and linkages have been formalized very recently. Not surprisingly, the numbers are relatively low. Accessing the governmental system is still a challenge. There are timing problems for clinic services that serve the needs of sex workers who operate during unconventional hours. Stigma related to treatment (ART, TB, OI) as evidenced by problems of address verification must be addressed. Acceptance of HIV testing has not reached the community at large. Only 45 - 50% tested among active community members. While the numbers of mobile clinics have increased, according to community members from Pedapudi, the frequency of mobile clinics may need to increase. In the interest of supporting sustainable service mechanism, this poses a challenge since APSACS mobile clinic services are limited to 4 clinics per quarter for 1000 in number.

Arogya Brundam needs to do more to follow up cases and their contacts for STIs. The health cards are recognized by less then 30-40% of local practitioners. However, 90% of practitioners recognize the referral slip. Duplication of cards identifying need for services has led to some confusion. SCAs and ORWs should work along medical practitioners to stream line a workable system.

While a supportive CBO environment is evident, there is little or no work being done to address **discrimination** in a focused and direct intervention with the aim to *prevent* stigma. Sex workers face discrimination on two fronts-- related to their positive status and their work as a sex worker. But even within the CBO community, sex workers are reluctant to disclose their positive status. According to SWLHA members, most sex workers do not disclose their status even among each other. CARE staff claim that out of about 200 positive sex workers, 120 are associated with SWLHA. But it appears that they do so in a discrete manner. One highly respected CBO leader recently died before ever disclosing her status. Some sex workers report that condoms are stigmatized since clients believe that only HIV positive sex workers insist on using a condom. Stigma and discrimination is also experienced when accessing services. While SWHALA and the health committee are aware of the problem, they have not have a well developed a plan to address it.

Although SAKSHAM staff have received FHI training, on-site FHI support has not taken place over the past five years. According to FHI, Avahan instructed them not to provide SAKSHAM with the standard clinical on-site support that had been provided to other Avahan partners.

4.2 Is Nari Saksham prepared to manage project implementation?

4.2.1 Project implementation benchmarked by NACO

Nari Saksham is a federation of 11 committed CBOs with 1205 registered members. It has a history of supporting advocacy initiatives through a number of leaders and institutionalized mechanisms such as the CIT, cultivated over the past five years. These leaders have assumed key responsibilities as SCAs, outreach workers, community consultants and most recently senior-level wing positions that work collaboratively with the district officers and the program manager.

Specifically, Nari Saksham governing body consists of an executive Committee (7 elected members), and a core committee (22 elected members). Up until the recent Nari Saksham election in March 2009, the executive committee was elected annually through transparent and democratic processes. Nari Saksham has a history of revolving leaders who have worked diligently and often heroically to build Nari SAKSHAM and the federated CBOs to what they are today. Executive committee members consist of Nari Saksham most critical leaders, representing the foundation of all future Nari Saksham work. In order to remain unbiased, executive and core committee members are not salaried.

An active and dynamic NGO network, called Godavari Mahila Samakhya (GMS) exists at the district level in East Godavari. Monthly meetings of this community network are fully attended by five CBOs, including Nari Saksham. Nari Saksham plays a strong role in supporting this network. The frequency of these meetings takes place on a bi-monthly or quarterly basis. All members in the executive body are not SCAs. Similarly, the Nari Saksham executive body consists of non-SCAs.

Nari Saksham faces key institutional challenges which need to be overcome before they can assume overall program responsibilities. Most critical is related to its leadership. While the model appears to balance the need to maintain CBO neutrality and the need to ensure CBO commitment, Nari Saksham executive committee demonstrated limited capacities to lead. For example, core committee members were unable to articulate their vision, mandate or priorities. They were not able to articulate key aspects of CBO accounting related to vouchers, recent deposits and expenditures. According to Nari Saksham members and CARE staff, Nari Saksham relative weakness is due to three primary reasons: 1) The new executive committee was recently elected and has had only one month in their official positions. 2) The highly capacitated Nari Saksham members are now employed in managerial (wing) positions. Not only are these recent Nari Saksham employees the most literate, they are Nari Saksham's most esteemed leaders. 3) Some of Nari Saksham's early leaders have

died of AIDS. Key leaders, who are often credited for building and growing Nari Saksham to what it is today, have passed away in the last two years.

As described above, Nari Saksham must **improve managerial**, **administrative and financial capacities**. Compared to leadership capacities borne after years of experience making mistakes, supportive coaching and mentoring, much-needed management and administration skills should not be considered insurmountable. The need for literacy and numeracy skills, obtained through non-formal education, should be re-considered.

4.2.2 Communities' presence and ownership

Structural intervention initiatives appear to be taking place together with key stakeholders. According to interviews, CBO meeting minutes and activity reports, more than four to five CLSI activities are held every month. The table below illustrates the range of initiatives designed to generate income (e.g. Nari Vihari and Naari Bhoianaahala) and disseminate information (e.g. Naari Dhwani). CARE staff from both Delhi and Rajhamundary continue to provide support to these activities. The communities' creative resources are secured through the cultural group, Nari Kalavedika, which delivers HIV prevention and care/support messages. During the last year alone, Nari Kalavedika conducted eight large events and several small events. SWLHA is a particularly inspiring group. Nari Saksham developed guidelines to support SWLHA members and mobilizes resources for them through events such as their annual "musical night" show. These initiatives helped to develop commitment and leadership skills among Nari Saksham members. Perhaps most importantly, these represent activities which cultivates solidarity across the membership. As seen in the box below, all nine community led initiatives are led by community members and seven of these have only community representation. Organization and coordination responsibilities are assumed by community leaders.

Structural Intervention Initiatives

Community led institutions	Description	Membership
Arogyabrundam	Health committee	SAKSHAM staff and community members
Grain Bank	Assured food supply to positive sex workers	Community members only
Naari Bhoianaahala	Community Kitchen: low cost nutritious food; income generation	Community members only
Naari Dhwani	Quarterly magazine	SAKSHAM staff and community members
Naari Kalavedika	Dance, drama and music: cultural wing	Community members only

Nari Kalavedika team in action

Naari Vihari	Van for mobile clinic and income generation	Community members only
Crisis Intervention Team	Crisis intervention, trafficking, violence, dealing with police	SAKSHAM staff, external stakeholders and community members
SWALHA	HIV + sex workers	Community members only
Vanita Shakti Shikhana Kendram	Training Resource Center (led by CBO Vanita Shakti Mahila Sangam)	Community members only

Strong leadership capacities observed across the six CBOs and CLSI initiatives.

The six wing positions are paid employees of the apex CBO, Naari SAKSHAM. They consist of the following: project coordinator (1), outreach coordinators (3), clinic counselor (1), and administrative assistant (1). During the meeting with them, they demonstrated exemplary knowledge, commitment and skills to assume responsibilities when they graduate. Approximately 90% of CBO leaders are actively implementing plans developed by themselves. The leaders demonstrated evenhanded problem solving, establishing their ability to be reliable and manage obstacles during difficult times. For example, the recent dismissal of a Nari Saksham leader was decided by the former Nari Saksham core and executive committees with strong input by the federated CBOs. Similarly, Nari Saksham staff managed a difficult altercation between two groups represented by NGO partners. According to the knowledge Olympics organizer, Nari Saksham overcame the differences between the NGO groups who threatened to leave the event. Because of their intervention, the event was able to move forward effectively and without further setbacks. Both situations demanded sophisticated problem solving and conflict management skills that Nari Saksham members effectively assumed.

Some **challenges** must be considered. As mentioned earlier, management and administrative skills are lacking among CBOs, particularly the newly elected members of Naari Saksham. SWLHA was formed, from a need that emerged from the sex workers themselves in August 2007. While it is committed to the needs of positive sex workers, SWLHA requires more direction and strategic planning capacities to move forward. Structural interventions to address stigma, for example, should be considered as a key SWHALA mandate shared with Nari Saksham. More must be done to increase CBO membership. As seen in several CBOs across India, CBO and CLSI leadership is limited

to a few committed members who are assuming most of the responsibilities. Not only will this lead to higher burn out, it will limit the relative potential of impact and its sustainability of community led interventions. , When this was discussed with CARE they assured the team that none of the leaders have dual responsibilities, apart from the executive team members. Those who have paid positions such as SCAs, CCs, and ORWs, cannot hold electoral posts in their apex CBOs or paid positions in the community initiatives.

It was unclear how capacity was built among staff and community members. SAKSHAM did not follow capacity-building, plans or curricula. For example, the team did not see training curriculum or agendas that were followed. Rather, it appeared that capacity building took place as an adhoc manner. Consequently, knowledge- and skills-levels among CCs, SCAs, and ORWs appeared to be uneven. This may be because there was no system for building capacity, consistent to roles and responsibilities for each designated positions. This is also making it difficult for them to monitor performance.

4.2.3 CARE's commitment and attitude to build community ownership

According to respondents who have known CARE SAKSHAM since its inception, CARE staff has been upfront about transferring capacity to Nari Saksham and partnering CBOs from its early days. Several examples to this end include ongoing mentoring, most recently through the wing-position system, so that Nari Saksham staff can assume programmatic responsibilities. With the aim to transfer responsibility, the demonstration officers (DOs) began working as on-the-ground CLSI implementers. As time progressed, DOs became facilitators rather than actual doers. As observed by an immersion participant,

We saw Nari Saksham in the forefront… they are managing, rather than CARE staff in the front. CARE stayed in the backside. It was impressive. NGO Immersion Participant.

Over the past year, CARE staff have handed over much of the day-to-day responsibilities to SCAs and outreach workers. Instead of leading, they are observing and supporting. This has led to SCA confidence and is laying the ground work for eventual CBO transfer.

During the first three years of SAKSHAM's project cycle few systems were in place. SAKSHAM's early managers focused more on forming CBOs, community initiatives, and advocacy and less on strengthening systems and communities' managerial capacities. Targeted HIV interventions were also overlooked. According to CARE staff, this was because they focused on their role as capacity building partner for CLSI. Due largely to demanding community needs some of the contractual obligations were not followed. Community members and staff were not adequately accountable to administrative procedures. According to CARE staff, this is due to a lack of role clarity and understanding of their respective job descriptions. In 2007, the newly formed Delhi-based team was forced to manage a disarray of systemic problems that had been neglected from 2004 - 2006. For example, Nari Saksham purchased a van that was not properly registered. Funds were not properly managed and accounted for across GMS

and Nari Saksham CBOs. These problems resulted in a number of scuffles which gave rise to internal strife among the staff and community members over the last two years. Ongoing wrangling and struggles for influence emerged. Under the new leadership, to the credit of hard working staff in both Rajhamundary and Delhi, effective systems are now in place.

CARE staff must reconcile a number of **challenges** in relation to aspiration of project participants and the organization itself. While a certain amount of heavy-handed supervision from Delhi may have been necessary, given the need to manage administrative and management crisis over the past two years, there is a strong feeling that Delhi's engagement must now become more evenhanded and detached. Now that systems are in place and leadership problems are resolving, the challenge now is to balance the relative influence of Delhi and Rajahmundhry staff for Nari Saksham's eventual programmatic leadership and control.

Another lacuna is the lack of understanding, among Nari Saksham and CBOs that a transition plan exists. This demonstrates that CARE still maintains overall control at a time when a transfer of power to CBO partners and/or Avahan NGOs is imminent. When CARE staff was asked about this, they reported that a transition plan was developed in consultation with community representatives in two project management workshops in Vishakhapatnam and Kodaikanal. The current elected leaders may not be aware of this. However, former executive body members - community consultants and wing positions - took part in those discussions. CARE planned to roll-out the transition plan based on donor decisions about the future direction of SAKSHAM.

4.3 Does the learning site in Rajahmundhry have the capacity to serve as the center of a learning strategy?

The learning site runs **two (flexible) learning curriculum/circuits** which are adapted to needs and expectations of participants. The learning site aims to meet the needs of their clients through support and mutual development of learning objectives. As a SACS team leader reported,

We had nine learning visits planned. SAKSHAM was the most pro-active, flexible and helpful. They even helped with cost sharing.
Team Leader, SACS

Approximately 36 immersion events took place over the past 4 years. According to training records, approximately 400 CBO members, NGO staff, state lead partners and government staff through SACS and NACO have participated. All the respondents[5] who

[5] Immersion participants from Delhi SACS, Delhi-based NGOs, a North-East based NGO (Orchid), and two AP-based NGOs (Kottapeta Mahila Mandali in Gunter; Hylep Lepra Society in Hyderabad)

participated in the immersion expressed overwhelming appreciation for the learning experience. As one participant reported,

When we were in Rajahmundry, we saw collectives – the CBO president together with the police officials. We saw that they were sitting equally with these higher officials! We were so stunned and knew something special was happening there.
NGO Project Coordinator

As a result of their immersion visit, participants recounted, with excitement, several learning e. Most of them declared that once returning to their home sites their teams incorporated several CLSI concepts and activities, as seen in their modified action plans. For example, some learning participants described how their newfound understandings of linkages between services and CLSI made them believe that communities could assume programmatic responsibilities. Examples of knowledge gained include:
professional, yet friendly, clinic settings;

staff's roles seen in the back and CBO members in the forefront;

constructive relationships with media, police, and health care providers;

Managing the DIC , especially norm setting for each member;

Sex workers voicing their rights with wisdom and confidence;

Organizing meetings with community stakeholders.

Some experiences led to the kind of **learning that helped re-invigorate or restore project components** that were losing impact. For example, one of the learning participants had described an unfortunate split in the executive committee and the eventual break-up of her partnering CBO. After the NGO manager and a former CBO leader experienced a three-day immersion in Rajhamundary they described a personal and organizational transformation that led to the re-emergence of the CBOs which had disintegrated a few years back. Annex six lists quotes illustrating the variety of learning opportunities that took place during their immersion workshops. The quotes were collected among informants across the four sites visited by the evaluation team.

With a strong understanding of CLSI (in theory and practice) **Community Consultants appeared to have clear concepts of their roles** as both trainers and active Nari SAKSHAM members. Community consultants come with a wide range of experiences - once working as SCAs within SAKSHAM - providing the necessary skills to train by example. When meeting the community consultants, the evaluation team noted that they could describe the details of forming a CBO. Community consultants rely on experiential teaching methodologies, through immersions, as they once learned through DMSC.

Several **toolkits** were developed over the past two years. Six out of 10 modules were reviewed by the evaluation team. An additional four are awaiting approval from Avahan.

The six reviewed modules are based on community consultation, adaptation to context, expert consultation and pre-testing as described in the box below.

Toolkit Development and Dissemination

Identification of Need: This takes place when specific capacity building inputs are determined to be lacking and when it is determined that no other tools of such nature exist.

Development of toolkits: Technically competent consultants, working under the guidance of SAKSHAM staff, develop a first draft of a toolkit based on learning-site experiences.

Field-testing of toolkits: The first draft of the toolkit is used in the field and overall feedback is solicited. Necessary corrections and modifications are made based on the solicited feedback. In many cases, the toolkit was field tested in other Avahan locations.

Final review of toolkit: Before the toolkit is finalized, the draft versions are posted on the e-avahan website for comments and suggestions. An international consultant, reviews the draft toolkits, for both technical accuracy and editorial purposes. Comments from e-avahan and other experts are integrated accordingly.

Dissemination and Use: The modules are used during the immersion visits as a supplement to the curricula. Participants are led through some of the exercises.

The toolkits appeared clear, easy to understand and relevant to programmatic needs. They synthesize complexities, inherent in problems found in the field such as unequal power dynamics and adaptive management.

APSACS expressed appreciation for process documentation of cases and Nari Saksham which is valued by the government.

A few learning Site challenges were also apparent. The separation of the learning and demonstration sites impedes prospective learning opportunities through a capacity-building program that is imbedded in the field. Because they have separate lines of accountability, the learning site staff are not well integrated into the SAKSHAM team. The resource center is separate and isolated and used infrequently. However, CARE staff report that some of the community and staff use the resource center according to their convenience and need. Learning does not emerge out of practice but rather from modules and curricula developed separately. Key community consultants are hired to build capacity of immersion participants, but it is not part of the daily responsibility of community members across Nari Saksham. Perhaps most importantly, community members are not leading the learning initiatives at key points of entry, including: planning, implementation and evaluation.

Only some community consultants have received training (e.g TOT). Variable knowledge, awareness and capacity among community consultants Immersion program: because of the separation between the learning and implementation sites, knowledge sharing opportunities are fragmented and, possibilities for NS to grow a learning component to their mandate is undermined.

The toolkits were developed within the SAKSHAM context only. More could be gained when drawing from tools used by other Avahan partners. The purpose of the toolkits is not always clear. Lastly, there is no clear dissemination strategy of the documents that were produced.

Perhaps because it was not created by the community, the **resource center is under utilized** by community and the Avahan community at large. There is little knowledge and understanding of who Nari Saksham is. As one partner noted,
Who? Nari Saksham? We know CARE but we don't' know Nari Saksham.

5. Conclusion

The findings reveal that SAKSHAM has reduced HIV vulnerabilities through the CLSI approach. This is most evident by observations of communities' show of strength to reduce violence, claim entitlements, and build CBO leadership. While HIV interventions were weak in the early years, they have shown remarkable improvement since 2007. More needs to be done to strengthen CBOs' skills in adaptive management, strategic analysis, planning, and sustainability. SAKSHAM must continue to stay on course to deliver targeted interventions to continue improving HIV outcomes.

The immersion program participants gave extraordinary accolades to SAKSHAM for their immersion experiences. In all cases, substantive learning, drawn directly from the field, transformed their programs. More needs to be done to strengthen research, documentation and materials development, to progress SAKSHAM's learning component so that it is more strategic and focused on key CLSI features.

6. Recommendations

6.1. Adaptive Management, leadership and oversight

Given the novelty and complexity of a CLSI approach to improve health outcomes, SAKSHAM should consider organizing an advisory committee in the second phase. An Advisory Committee with expertise in technical areas such as HIV/AIDS, CLSI, knowledge management, and research is necessary to reinforce technical excellence.

Nari Saksham and the federated CBOs demonstrate both the necessary analytical skills and aspirations to lead a TI program. However, intensive training on management and administration must take place so that they can handle the day-to-day activities. Literacy and numeracy training, using non-formal Frerian methods should be considered so that new leaders that read and write can emerge. For those CBOs that are ready, bank accounts should be established. Nari Saksham must be able to provide fiscal accountability.

Developing and support internal and external interactions through effective relationships should be considered. This can be seen through managerial practices, coalition-building and sharing. CARE may consider:
Supportive supervision from CARE staff through robust - while also distant, humble and facilitative - adaptive-management practices. For it to succeed SAKSHAM must be led from below and less from above, particularly now that crisis have been largely overcome. In so doing, the center of gravity of the program should be located in Hyderabad and Rajhmundary with facilitative backstopping from Delhi
Building relationships with external stakeholders with humility and eagerness to learn. AP-based relationships with NGOs, government and other stakeholders must be established and nurtured so that SAKSHAM becomes more visible and engaged with state-level activities. In addition to expertise in HIV/AIDS and CLSI, senior staff should be proficient in knowledge management.

CARE may consider conducting an internal assessment to explore the effectiveness of SAKSHAM's governing structures within the CBOs, CLSI initiatives and the TI activities should be explored. Several leadership and management concerns can be reconciled once deeper understandings of relationships, decision-making dynamics, systems are at play in relation to respective roles. This is not an easy task, given the dual mandate to both management and build a movement.

6.2 Vision, planning and sustainability

Instead of reactionary case-based responses, as is used in the CIT, NS/CARE should consider ways to determine priorities in future programming. Once that is fully explored, the SAKSHAM team may want to develop a vision and operational plan for the second phase with *prevention* in mind. Such a plan should focus on deepening understandings of CLSI through applied and participatory inquiry. Instead of reacting to problems, at the heart of many CBOs, Nari Saksham may consider being pro-active in changing structures that lie at the root of sex workers' vulnerabilities. While protecting individual victims from violence and discrimination is important, more time may be spent on eliminating its causes- discrimination at structural, ideological and operational levels. This requires an intersectional framework to demonstrate how "multiple systems of discrimination" including gender, caste, ethnicity, positive status influence sex workers' vulnerabilities. In so doing, SAKSHAM may want to focus on collaborating with parallel civil society groups to ensure that a broad-based movement will support mutual objectives, particularly in light of CARE's eventual departure.

Nari Saksham may consider consolidating the CBOs that have less then 250 members. This would not only strengthen the smaller CBOs, it would secure needed support, in numbers, to fulfill its mandate. Both SWLHA and Arogya Brundham conduct impressive health-related work. While service statistics have improved, much more needs to be done to enhance HIV testing and follow-up HIV services.

6.3 Strengthening programs

Instead of focusing on CIT responses to violence, use systematic **advocacy strategies** after identifying policy-change aims. Each strategy should focus on selecting primary and secondary audiences, developing targeted advocacy messages, us appropriate messengers and tactics that are geared towards prevention. Building and strengthening coalitions with parallel movements (e.g. women's rights, LGBT, positive networks, dalit) and civil society organizations are necessary for SAKSHAM's next phase. Step-by-step community-based advocacy guidelines can be developed.

Microfinance finance may be an alternative source of income for CBOs which can help sustain them, as a collective. Savings and credit schemes, using a cooperative model might help the CBOs and Nari Saksham meet their operating costs. That is, members will contribute the membership fees and share capital. Funds will be lent to the members who are needy and willing to undertake the income generation programmes. This not only diversifies their income, it provides opportunities for aging sex workers to earn so they rely less on underage sex workers and unsafe behaviors that would place them at risk. A separate study can be initiated for income generation by undergoing market analysis and the relative interest of sex workers. Specific exercises such as Participatory Skill Resource Mapping can be undertaken to identify the latent potential of community members.

While significant improvements have been made, Care may want to continue focusing on improving NACO benchmarks related to STIs, HIV testing, and ART treatment. To do so, SAKSHAM should secure TA from technical experts such as FHI, assuming that Avahan will agree. It is highly recommended that SAKSHAM continue to strengthen the CBOs' focus on targeted interventions, as seen in SAKSHAM's encouraging progress observed over the past two years. The reviewers suggest that SAKSHAM support CBOs, SWLHA and Arogya Brundham to become more active in community based demand generation for testing, care, support and treatment.

The SNA mapping exercise completed by HLFPPT in January 2007 reports 1075 FSWs in the region which was later reconciled to 1150. A fresh mapping exercise is required since the actual number is closer to 1700.

Given the level of sophistication observed among SAKSHAM members, focus on developing a stigma and discrimination reduction strategy led by SWLHA to address the double stigma of HIV positive status and sex work.

6.4 Learning Site

Consider **combining learning and implementation sites** so that dynamic cross-learning between the immersion participants and the SAKSHAM community takes place. Knowledge management expertise is required but should not replace leadership and learning strategies led by the community.

Develop a **learning strategy**, based on a learning assessment, using multiple learning methodologies, drawing on knowledge-management expertise together with Avahan partners and the community.

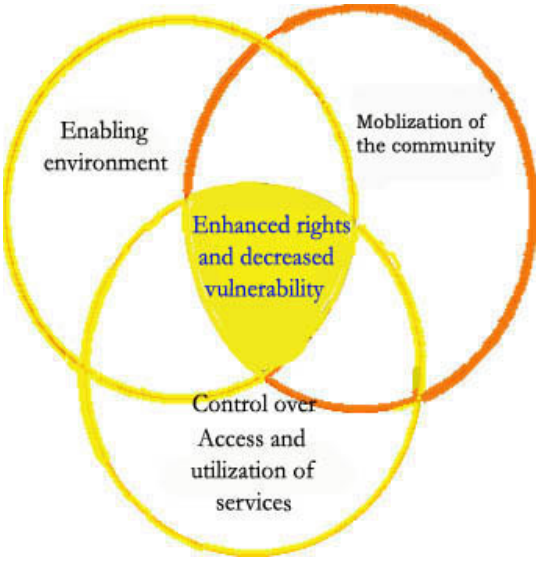
Conduct in-depth analysis of key learning areas to better understand CLSI and its impact on health outcomes. Identify focus areas to develop deeper understandings of complexities as well as levels and types of engagement that are being tested in SAKSHAM and across Avahan sites. Despite its challenges, it is critical to balance the need to generate professional-level papers that are polished, professional, and publishable with approaches that are participatory and driven from the bottom up. This is a unique challenge that would make a considerable contribution to the development sector. Thematic areas may include: crisis management (e.g. ramifications of refusal to bribe), layered governance structures, intersectional influence of gender, sexuality, caste, positive status on vulnerability, CBO development, prevention of under-age sex work, stigma and discrimination reduction, cross-movement work (with women's rights groups, dalit groups, farmer groups, and LGBT groups). It is also important to focus on district-, regional- and state-level structural changes that emerge locally.

Develop step-by-step guidelines on participatory process documentation using a range of media sources. A dissemination strategy should be developed early on. Toolkits and documentation should be used widely across SAKSHAM and with immersion partners. When translated into other languages, more pictures, diagrams, boxes and clear space should be integrated so that they will be useable by a semi-literate audience. The process documentation can be supplemented by a video which can be translated into a number of languages with a focus on various CLSI components. A dissemination strategy should be developed to enhance the greatest amount of cross learning.

Over the last two years, CARE SAKSHAM has generated several curricula. These need to come together in an overall program strategy with systematic planning guidance.

Annex 1. SAKSHAM and Community Led Structural Intervention

Through the Community Led Structural Interventions (CLSI) approach, The SAKSHAM program moves beyond traditional public health and behavioral change interventions to reduce structural inequities. In so doing, CLSI positions community members as leading change agents, thereby placing ownership of the processes and outcomes in their control.



I. Community Led Structural interventions
With the aim to enhance rights and decrease vulnerabilities, the CLSI approach consists of three overlapping components. These include:

Building an enabling environment to sustain practices;
Mobilizing communities by initiating a process of active participation to establish their rights and privileges; and,
Control over access to and utilization of services by the sub-population

CLSI supports individuals and communities to plan, implement and monitor HIV prevention programs.

Enabling the Environment
Community members advocate on their own behalf through community led advocacy and crisis intervention actions. To ensure effectiveness, SAKSHAM enhances: communication skills, self-esteem, leadership qualities, and knowledge and awareness of sex worker rights.

Community led advocacy through meetings, trainings and invitations to events with police, media, and the District Administration.

Crisis Intervention SAKSHAM created a 24-hour crisis response system. This response relies on a chain of communication among community members. They are on-call and respond to crisis as they arise throughout the day and night. Depending on the severity of the case, community members and/or CARE staff and lawyers appear at the police station to negotiate sex workers' release from jail when she is illegally detained.

Community mobilization
As peer educators, **Social Change Agents (SCAs) lead by example**. They provide information on risk reduction and help community members access services. In the CLSI model, SCAs play a large role than peer educators who generally focus on behavior change. SCAs support collectivization processes necessary to develop a strong CBO.

Drop–in–Centers (DICs) are multipurpose safe spaces that allow the community members to come together to think, act, and lead CLSI processes. These spaces enable communities to collectivize based on common concerns and community actions. Because

DICs are private, they provide opportunities for community members to share stories, personal fears and handle crises in discretion. It is for these reasons, DICs are comfortable home-like rooms, representing the individuality and interests of community members.

Community based organizations (CBOs) are grass-roots collectives within a given geographic locale and social identity – in this case the sex work typology. Sex worker mobilization and organization is organized within the 11 cluster-level CBOs and one federated CBO, Nari Saksham. In addition to the collectively-developed objectives, each CBO aims to foster community leadership and identify and respond to shared concerns. The formal registration of these CBOs leverages their efforts in advocacy, crisis handling, and trauma management, apart from the routine outreach related activities that they undertake.

Increasing Control over Access to Services
Consistent with NACO III, SAKSHAM recognizes the intrinsic linkages between sex work, STIs and HIV. What is unique to the CLSI approach is that **STI clinics are also community managed**. As a result, community members proactively access health information and services. Not only do community members avail these facilities, they also motivate others to do so. **STI check ups, surveillance, and follow-ups** represent routine activities of this CLSI component. The community plays a pivotal role in **monitoring and evaluating services** on a systematic basis. For example, the Health Committee or "**Arogya Brundham**", supervises and monitors clinic activities, decides the location and timing of the mobile clinics, depending on where the outreach is to be intensive. The STI Management Committee has about twenty-five members, consisting of community members and doctors. Condoms are disseminated by SCAs and managed by the CBOs.

Annex 2. SAKSHAM Final Evaluation Framework and Tool

Evaluation Objectives and questions	Respondents And Data collection method	Resources for Desk Review
1. Has SAKSHAM reduced HIV vulnerabilities and enhanced rights? Specific Community interventions: What worked and what didn't work?		
1.1 Enabling Environment: What <u>policy</u> changed through the items listed? Ownership? **1.1.1 Advocacy meetings** with KSH (Key Stakeholders) Police, Legal cell authority, District Health Officials, APSACS, and Media *What changed (to support advocacy work) as a result of these meetings?* 1.1.2 Organization of small and large scale **public events** (how to handle funds, functionaries, work in decentralized manner, subcommittees, public authorities) inter-CBO meet: Melody with message musical night (2007), Naari Swara Lahri musical night (2008), Naari Swara Sangamam musical night (2009) (case), World AIDS Day, International Sex Workers' Day, 1.1.3 Active engagement in **GO-NGO** programs: Service provider attitudinal change: ASHA program, Pulse polio, Traffic Week, Police sensitization (SWs as para legal workers), Red Ribbon Express, APSACS TOT, Child Rights forum. *What changed (to support advocacy work) as a result of felicitations?* **1.1.4 Information sharing**: CARE India Website, Avahan Website, Israel Post, CARA International Board meeting, Study dissemination events, Human Interest Story Competitions, Naari Dhwani, Audio-Video productions, Press meet, Press release and TV (Cable) interviews, Publication of documents (reflected in NACP III HRG manual also) *What changed (to support advocacy work) as a result of info sharing?* **1.1.5 Felicitation** of KSHs: In all major events and celebrations local MLA, MP, Mayor, the MLC (Legislative Council) Dalit Mahasabha, Legal Cell Authority, Health officials, Women and Child Development Department Officer, Nehru Yuvak Kendra in- charge, NGO heads etc. are felicitated *What*	CARE staff (FGD, KII) Nari Saksham (FGD) Godhavari Mahila Samakhya board, (FGD) president (KII) SRB (1.1.8) PLHA Network (1.1.9) CIT (1.1.10) KPs: Local CBOs (6 of the 11)- FGD/KII observation, records, KPs: SCAs, Outreach Workers (FGD, KII) Stakeholders (KII) medical ADMHO Registrar of societies Police Lawyers Political leaders Informal power (KII) brokers (pimps, brothel owners, Anju/baju, General Community: (not 1.1.3	1.1.1 Rambabu Advocacy Meeting Reports; MIS- monthly report, NACO 1.1.2 Report of CBO Meet 2007-2009; event management document 1.1.3 Red ribbon express Report, ASHA Report, Pulse Polio Report, 1.1.4 Amelia and Nabesh to give reports on these. 1.1.5 no reports

changed (to support advocacy work) as a result of falicitations? 1.1.6 **Exposure Visits**: Exposure visits organized for CIT (Crisis Intervention Team) members to Sangma, Bangalore; for PDAPSACS to DMSC Sonagachi, *What changed (to support advocacy work) as a result of these visits?* 1.1.7 What is the police advocacy strategy? What changes in police behaviors and policies resulted? 1.1.8 Mobilizing resources (incl government)? How has NS mobilized resources? How funding mobilized within CARE? 1.1.9 Is there a functional* Self-regulatory board (SRB)? What is its mandate? Does it have authority/ownership? Is it sustainable? Transparent? Has it achieved its objectives? 1.1.10 Is there a functional* PLHA support group? What is its mandate? Does it have authority/ownership? Is it sustainable? Transparent? Has it achieved its objectives? 1.1.11 Is there a functional* CIT? legal awareness? What is its mandate? Does it have authority/ownership? Is it sustainable? Transparent? Has it achieved its objectives? 1.1.12 legal awareness: lawyers awareness training; CB for CBOs		describing. In every program especially Dowalesram (most violence) 1.1.6 Bangalore visit to Sangama (report); PDASACS influenced by exposure visit to DMSC 1.1.7 Policy strategy – Ram Babu 1.1.9 meeting minutes; SRB concept (from Nabesh) 1.1.10 Reports on Swasthi Karuna and Mumta evolution 1.1.11 CIT (from Nabesh); 1.1.12 legal awareness booklet
1.2 Peer learning and Peer progression Group and individual level empowerment? Transparency? **1.2.1 Collectivization**: CBO formation: Meetings: Sub-committee, Executive Committee, Core Committee, Crisis Intervention Team, Arogya Brindum, Naari Dhwani, Naari Vihari, Narri Bhojanshala; Inter CBO meet, Inter DIC meet *Reaching goals by means of CBO control and ownership?*	CARE staff (FGD, KII) Nari Saksham (FGD) Godhavari Mahila Samakhya board, (FGD) president (KII) KPs: Local CBOs (6 of the	1.2 CLSI booklet gives complete concept of peer learning; peer progression document 1.2.1 CLSI booklet

* Regular meetings? Minutes? action items followed up? formal membership? have they identified needs? Address issues raised? Affiliated with network?

Sustainable- See assessment tool. (functionaries, governance, and policies in place)? 1.2.2 Safe space creation: 11functional* DICs **1.2.3 Capacity building**: 1. Mapping 3. CBO management, Peer Education, RTI/STI/HIV/AIDS micro finance, micro planning, use of various tools, vocational trainings, clinical practices, Syndromic Case Management , Life Skills education for Adolescent daughter of sex workers *Community ownership? Sustainable?* 1.2.4 **Mentoring and Leadership Building:** ORWs and Wing Positions, Arogya Brindum, Sub-Committee coordination, *Are these leaders stewards of resources (human, financial and otherwise) while focused on results?* **1.2.5 Adherence to democratic processes:** fair annual elections Good governance (ie. Shared decision-making)?Non-SCAs in executive body of district community network (GMS) and CBO? 1.2.6 Community led initiatives for well being, crisis management, image building and sustainability (to ensure sustainability, reduce stigma, addressing crisis): cor crisis: SWLHA, Naari Bhojanshala, Crisis intervention Team; *Is community able to manage: crisis? Discord btwn CBOs? Btwn community members? Independent? Mature behavior?* STI/HIV prevention: Arogya Brindum (STI/HIV prevention) Stigma/image:, , Naari Vihari, , Naari Kala Veedika, Naari Dhwani, Vanita Prashikshana Kendra, Grain Banks *Structural intervention plan led by district community network?*	11)- FGD/KII observation, records, KPs: SCAs, Outreach Workers (FGD, KII) Stakeholders (KII) Registrar of societies Police (1.2.6) Lawyers (1.2.6) Political leaders (1.2.1, 1.2.6) Informal power (KII) brokers (pimps, brothel owners, (1.2.6) Aju/baju, General Community: Arogya Brindum, Crisis intervention Team, Naari Vihari, Naari Bhojanshala, Naari Kala Veedika, Naari Dhwani, Vanita Prashikshana Kendra, Grain Banks	1.2.2 DIC documentation (in immersion) and process documentation of SAKSHAM. Nabesh? 1.2.3 Mapping: Social Network Analysis Report by Hlfppt; FOL reports; CBO management training report (ask Shanta) 1.2.4 Wing position Concept note (Nabesh) 1.2.5 NMS Election 2008-2009 Report (Shanta) 1.2.6 CLI reports (CD Rom) documentation avail on all
1.3 Control Over Access to and Utilization of Services 1.3.1 Community led **clinic management**: Arogya Brindum, the Health; simple para medical skills, syndromic case management, social marketing, drug store maintenance, counseling, condom procurement & distribution and STI trend analysis. *Quality? Extent of community ownership? Community Accesses functional STI system?*	Mahi (PM) CARE clinic staff, team leader (FGD, KII) Health committee (FGD) KPs: Local CBOs (6 of the 11)- FGD/KII observation, records,	
1.3.2 **BCC**		

1-1 (achievements/barriers), 1-group (achievements/barriers), events (target populations), IEC distribution, numbers reached, how this reach achieved, qualities of activities, quality assurance and quality improvement plan, how monitored?	KPs: SCAs, Outreach Workers (FGD, KII) Stakeholders (KII) medical ADMHO	
1.3.3 STI Program: **service delivery** Central Clinic equipped, 15-20 satellite clinics as per the need *Quality of service linkage an referral system? Ownership?* Identification of HCPs; Referral system; acquaintance of staff with STI symp; partner treatment, STI counseling, avail/access STI services; **CBO-PHC linkage building**: Regular meetings & workshops with PHC doctors and para medics, supporting them in pulse-polio, family awareness week, conduction of outreach clinic in local PHCs; Is there a functional STI and health services network?		
1.3.4 Counseling: Counseling training; type of counseling; report/case sheets maintained, FU?		
1.3.5 Condom promotion: condom demo, penis models? Myths and misconceptions, NTOs for priced condoms, avail/acces of condoms (free/priced), info gathering system?		
1.3.6 Peer Education: training? Role of PE, monitoring of PE, substance of PE, PE turnover, PE graduation?		
1.3.7 Org structure: How other activities feeding in program? Number of staff per proj requirement, training programs, further training needs, staff turnover, JDs, senior management; autonomy to project staff?		
1.3.8 MIS system: Community led service **monitoring**: Patient satisfaction survey, Health Cards distribution, Registers for referral tracking (ICTC, PPTCT,TBDOTS, PHCs), presentation and discussion of STI/Condom/Referral status in CBO meetings, clinical data recording and database updating *Quality?*		
2 Has SAKSHAM developed the capacity to serve as a learning site for other NGOs and CBOs? *What worked and what didn't work?*	Key CARE staff (KII) Donor, APSACS, DSACS Immersion NGOs/CBOs	
2.1 Quality of learning curriculum (e.g. learning circuits)? Internal CB for local CBOs and external CB for external CBOs/NGOs *Who has ownership?*	Immersion participants	Santosh to give training reports; Standard

		operating procedures (SOB)
2.2 Community members as trainers—community consultants? Capacity building of staff (KPs)? Level of quality? Level of leadership? Ownership?	Community consultants Rajamundary CBOs (in relation to election) Senior Demo officer ((Padma) Training coordinator DSACS Immersion NGOs/CBOs (XX)	Learning curriculum
2.3 Immersion program. Trainers are community members? Five and Three day curriculum. Did immersion meet expectations of NGOs, CBOs, SACS? What changed in beneficiaries' home programs? What worked? What could be improved?	Community consultants Senior community leaders (president, secretary) Senior Demo offivcer ((Padma) Training coordinator DSACS Immersion NGOs/CBOs (XX)	Immersion learning (1 year old—has changed); Revamped Immersion report
2.4 Modules, manuals and guidelines? Developed by the community? Pre-tested? Where and how utilized? Effectiveness? Changes in performance?	Nabesh Santosh (training coordinator) Pramod (Pathfinder), Sri-Ram (deputy director of Ashodya) DMSC? George (CARE) Most others haven't used apart from Power analysis module	Modules, manuals
2.5 CLSI resource center? (1 year) Mandate? Who uses? How is it used?	Shanta (doc officer),	

Changes?	Santosh (training coordinator), (early for impact, just describe)	
2.6 Knowledge sharing and management (audio, video): Documentation, productions and publications? Community involvement in Research? *How have these been disseminated? How have these materials been used? How do people have accesses to these materials?*	Audio/video: Shanta Research: Pop Council, ICRW, YALE Immersion visitors (reflection periods)	Audios/videos (Shanta) Research reports (FOL, Parivartan, Pop Council, UNFPA, Ford Foundation)
2.7 Community consultants (formerly CLCAB team)- Grant given to DMSC (Bachuta coordinated this) institutionalized to support SLPs, IPs and CBOs.	Bachuta (DMSC) Sri Ram Pramod State lead partners (Bitra-FHI)	CLCAB Concept note; DMSC report
2.8 Immersion participants: 1) have they met expectations? 2) change integrated in home program? 3) modified or new action plan? 4) challenges? Or improvements?	SACS, Orchid, Immersion sites in AP	Immersion reports; feedback/evaluations
3. Preparedness of the FSW CBO (Nari Saksham**) to manage project implementation?** Readiness of NS to implement TI, based on NACO guidelines? Collaboration on this with APSACS?	Key CARe staff (KII) Nari Saksham FGD/KII) KPs: Local CBOs (6 of the 11)- FGD/KII observation, records, KPs: SCAs, Outreach Workers (FGD, KII) SACS	
3.1 Performance of project implemented by Nari SAKSHAM as measured through standard indicators by NACO. Readiness of NGO	Senior Demonstration officer (Padma) Mahi (PM) Nari Saksham FGD/KII) Admin officer – financial management: (padmarani/laxmana)	Transition on process; MIS Report

	Wing position project coordinator (Manasa) Jose (team leader); Dora CBO president and secretary; CBOs (?) AP-SACS (kailash)	
3.2 Key communities' overall presence in the project? Planning, implementation, any activity. How much involvement is community or mostly driven by NGO or CARE itself.	Key CARe staff (KII) Nari Saksham FGD/KII) KPs: Local CBOs (6 of the 11)- FGD/KII observation, records, KPs: SCAs, Outreach Workers (FGD, KII) AP-SACS	Project management committee document (Nabesh) NS external consultancy contract
3.3 Commitment and attitude (social norms) of implementing NGO (CARE) to build community ownership? *Attitude of staff? Sensitivity of staff?*	Nari Saksham project coordinator (Manana); previous president (Jyoti); present president (Baby) KII NS FGD- KPs: Local CBOs (6 of the 11)- FGD/KII observation, records, KPs: SCAs, Outreach Workers (FGD, KII) AP-SACS	none

Annex 3. Final Evaluation Data Collection Schedule

Proposed Schedule for Final Evaluation					
DATE	ACTIVITY	PLACE	TIME	REMARK	Contact No.
6/4/2009	Meeting with SAKSHAM core team	CIHQ, Delhi		Anju to take care of logistics, Nabesh-Documents, Jose-Team coordination	Jose: 09310959794
7/4/2009	Internal planning meeting of FET	CIHQ, Delhi		Nabesh-All the docs to be provided in soft; Anju-Formalities completed,	Anju:09958840855
8/4/2009 to 12/4/09	Finalization of Methodology, Tools and Desk Review	Delhi-Hyderabad		Anju to support delivery of documents/logistics for field travel	
13/4/09	Meetings at CIHQ:	CIHQ, Delhi		Interviewers: Dr.Veronica and Dr.Dipanjan, Anju to coordinate	
	George:	,,,,,,,,,,,,,,,	9.00 AM		George-9811809530
	Dr.Dora Warren	,,,,,,,,,,,,,,,	10.00 AM		Dora - 9811334848
	Nabesh:		11.00 AM		Nabesh-9999767324
	Suman		12.00 AM		Suman-9810216440
	Gopal		01.00 PM		Gopal-9899426864
14/4/09	Meeting with Dr.Annie George	Delhi	Afternoon	Interviewers: Dr.Veronica to coordinate. Anju to support	Annie George-9000212279

15/4/09	Meeting with Dr.Ash Pachaury	IHC, Delhi	2.00 PM	Interviewers: Dr.Veronica and Dr.Dipanjan, Anju to coordinate	Dr.Ash: 9810024778
16/4/09	Meeting with DSACS	DSACS office-Delhi	10.00 AM	Interviewers: Dr.Veronica and Dr.Dipanjan, Ms.Nirupama Rao, Anju to coordinate	Pragya-09312701815
17/04/09	Meeting with Dr.Langkham, Orchid (10.00 AM at Care Office)	CARE office, Delhi	10.00 AM	Interviewers: Dr.Veronica,Dr.Dipanjan, Ms.Nirupama. Date and timings TBD, Anju to coordinate	Dr.Langkham: 9810999329
	Meeting with Ms.Tisha Wheeler at 11.30 AM in Gates office	GATES Office, Delhi	01.30 PM		Tisha's No.-9811846940
	Meeting with Ms.Usha Kiran at 12.15 PM at Gates Office	,,,,,,,,,,,,,,,,,,	02.30 PM		Usha 9811512032
18/4/09	Meeting with Bacchuda (CLCAB), Shamal Ghosh (DMSC Immersions) and Dr.Mitra (Graftee,AP)	DMSC, Kolkota	TBD	Intervier: Dr.Dipanjan Roy (meetings can be on 17 or 18the evenings. Exact timing to be communicated. Have informed them that Dr,Roy will get in touch with them)	Bacchuda-09748406001, Shamal Ghosh-09748406048 Dr.Mitra-09830023769
RAJAHMUNDRY (RJM) VISIT					
20/4/09	Arrival of the FET to RJM	Rajahmundry		Hotel River Bay, RJM	
	Ms.Nirupama & Ms.Jayamma reaching by Gautamy Express	Rajahmundry	7.00 AM	Ticketing, Pick Up & Hotel: Anju & Padmarani	
	Meeting with Media by Ms.Nirupama and Jayamma	Hotel River bay	9.30 AM	Mahi-Rambabu	
	Dr.Veronica and	Hotel River bay	11.00 AM	Ticketing, Pick Up & Hotel:	

	Dr.Dipanjan- arrival by flight			Anju & Padmarani	
	Close in meeting with SAKSHAM staff	SAKSHAM Office	1.00 PM	All the SAKSHAM staff to be present including the ORWs	
	Lunch	SAKSHAM Office	2.00 PM	lunch from Naari Bhojanshaala, Community Kitchen,	
	Team A- Visit to Thummalova DIC	Thummalova	3.00 PM	Respective DO to facilitate presence of CBO EC members, 2-3 SCAs and 10 Community members	
	Team B- Visit to Namavaram DIC	Namvaram	3.00 PM	Respective DO to facilitate presence of CBO EC members, 2-3 SCAs and 10 Community members	
21/4/09 Team A	Visit to Moramanda DIC	Moramanda	9.00 AM	Respective DO to facilitate presence of CBO EC members, 2-3 SCAs and 10 Community members	
	CBO meeting at Ravulpalem DIC	Ravulpalem Village	2.00 PM	Respective DO to facilitate presence of CBO EC members, 2-3 SCAs and 10 Community members, the CBO meeting can start after a working lunch.	
	Performance of Naari kala Veedika at Ravulpalem Village followed by an interactionwith NKV	Ravulpalem Village	4.00 PM	S/DO with FO-CI to coordinate	
	Meeting with Fr.Thomas at	Rajahmundry	5.30 PM	Mahi-Anandrao	

	PARA Trg. Centre				
Team B	Meeting with Mr.John Victor of Pragati (NGO) .	SAKSHAM Office	9.00 AM	Mahi-Anandrao	
	Visit to Loacl Health institutions: Hospital, STI Clinic, Lab, ICTC,DOTs Centre,GSL C&S centre etc.	Rajahmundry	10 AM onwards	Mahi-Deepa	
	Meeting with SWLHA (positive sex workers group)	SAKSHAM Office	12:00:00 noon	Mahi-Deepa	
	Lunch	SAKSHAM Office	01.30 PM	Padmarani (with SWLHA Team)	
	Visit to Dowaleshwaram DIC, If possible also meet the SI and the PHC Doctor	Dowaleshwaram	02.30 PM	Mahi-Anandrao	
	Visit to NS office and meeting with Naari SAKSHAM executive committee	Naari SAKSHAM Office	04.30 PM	Mahi-Jyothy	
22/4/2009 Team A	Visit to Peddapudi DIC and meeting with CBO (after the meeting, if possible have a brief visit to PHC also)	Peddapudi	9.00 AM	Respective DO to facilitate presence of CBO EC members, 2-3 SCAs and 10 Community members,	
	Meeting with other key stakeholders: Dr.Pawan Kumar, ADMHO, ART centre, DWCDO, NYK, CHANGES(NGO), St.Pauls Trust, Pratipadu Hospital	Samalkot and Kakinada	12 noon onwards	Mahi-Anandrao	

	On their way back from Kakinada could meet Nestam (MSM)	Rajahmundry	6.00PM	Mahi-Rambabu	
Team B	Meeting with General Community: Devraju, SGR Video, Sunny, Hotel,the AMG rep, landlord, Some neighbours, College interns from Social Work College etc.	Rajahmundry	9.30 AM	Mahi-Rambabu-Padmarani	
	Meeting with Arogya Brindum	SAKSHAM Office	10.30 AM	Dr.Deepa to to coordinate	
	FGD with SCAs	,,,,,,,,,,,	11.45	Mahi	
	FGD with Community Consultants	,,,,,,,,,,,	1.00PM	Santosh-Shanta to coordinate	
	Lunch	,,,,,,,,,,,	2.00 PM	Padmarani to support	
	FGD with Community Initiative coordinators	,,,,,,,,,,,	2.30 PM	Mahi-Jyothy	
	Meeting with GMS ex.committee	,,,,,,,,,,,,,	3.45 PM	Mahi-Anandrao	
	Meeting with Crisis Intervention Team	,,,,,,,,,,,	5.00 PM	Mahi-Rambabu	
23/04/09 Team A		SAKSHAM Office	9.00 AM	Mahi to coordinate. Voting could be adjusted according to meeting timings.	
Team A	Meeting with Paramedical staff	SAKSHAM Office	8.00 Am	Dr.Deepa to to coordinate	
Team B	Meeting with DOs	SAKSHAM Office	8.00 AM	Mahi to coordinate	
Team A	Meeting with ORWs	SAKSHAM Office	9.30 AM	Mahi to coordinate	

Team B	Meeting with Wing Positions	SAKSHAM Office	9.30 AM	Mahi to coordinate	
Team B	One team meets the Learning Site team, the other team continues position specific discussion	SAKSHAM Office	10.30 AM	Santosh-Shanta to coordinate	
Team A	Meeting with Doctors	SAKSHAM Office	10.30 AM	Dr.Deepa to to coordinate	
	Time for reviewing CBMS (Monitoring system) case tracking software / GIS /drug management/records/clinical protocols etc.	SAKSHAM Clinic	11.30 AM onwards	Deepa and Manohar to coordinate	
Team B	Meeting with FOL Team	SAKSHAM Office	2.30 PM	Sreenivas to coordinate	
Team A	Meeting with Admn Team	SAKSHAM Office	2.30 PM	Jose to support	
Team B	Meeting with Ms.Thota Maheshwari, Manager Implementation site	SAKSHAM Office	3.15 PM		
Team A	Meeting with Dr.Jose Sool, Team Leader	SAKSHAM Office	3.15 PM		
FE Team	Time for preparation /internal discussions	SAKSHAM Office	5.00 PM to 6.00 PM		
	Debriefing	SAKSHAM Office	6.00 PM	Padmarani to support.All staff to be present	
	FET departs to HYD / Guntoor	Rajahmundry	9.00 PM	Padmarani to coordinate	Mr.Venkat(KMM Guntoor) - 09440261961 and 08632212382

Guntur-Hyderabad Visit (24-04-09)					
Team B	Meeting with KMM and post lunch proceed to Hyderabad.	KMM Office	10:00 AM	,,,,,,,,,,,,,,,,,,	
Team A	Meeting with APSACS JD: Mr. Kailash	APSACS office	10:00 AM		
	Meeting with TSU (Dr.Rama)	APSACS office	11.00 AM		
	Meeting with Ms.Matangi, manager Avahan at 12 Noon (Place TBD)	TBD	12.00 nnon	Jose to coordinate	Ms.matangi 9000679680
	Visit to Tolly Chauky, Lepra project supported by Alliance	Lepra site	2.30 PM	Jose	
Report writing and presentation					
25-28 April	Individual draft reports			Dr.Veronica to coordinate	
30-Apr	Presentation by the FET	CARE office, Delhi	11.00 AM	Veronica- Jose	
5/5/2009	Final Report Submission	CARE Office, Delhi		Veronica and Team	

Annex 4. COMPARISON CHART OF KEY RESEARCH CONDUCTED IN SAKSHAM INTERVENTION AREA (2004-2009)[6]

	Key Indicators	Name of research and findings (in percentages)			
		Yale Study Round 1 (2006)	Yale study Round 2 (2007)	Pop council study (2007)	Ford foundation (2008)
A	Sex Worker Identity (statements that study participants agreed to)				
1	I am proud to be a sex worker	28	26		55
2	Sex work is immoral	76	69		38
3	Sex workers deserve rights like any other worker	86	91		96
B	Control over sex work (said yes to the questions)				
1	When I am conducting sex work, I decide the type of sex	54	75		
2	When I am conducting sex work, I decide the amount I charge	51	71		
3	I can decide about the number of clients I have in a day				87
4	I can spend the money I earn as I want				96
5	Can refuse to have sex if do not want to				98
C	Other sex workers will support me ……				
1	In case I am sick	35	58		85
2	In case I need money	35	45		54
3	I need somebody to take care of my child	44	60		35
4	I need food	32	50		53
5	I needs a place to stay	38	45		40
6	In case of client violence	52	70		

[6] Yale study: Project Parivartan, "Results of a Cross-Sectional Study of Female Sex Workers in Rajahmundry, Andhra Pradesh," May 2007. http://cira.med.yale.edu/parivartan/resources/reports/surveysummary_0507.pdf

Pop Council study: Mahendra, V.S., S. Mehrotra, B. Srikanthi, S. Panda, A. Sarna, A.K. Jayasree, R. Prasad and N. Rutenberg. 2007. "Identifying areas for linkages between HIV and SRH for vulnerable populations: An exploratory study to assess female sex workers' sexual and reproductive health needs" Research Update. Population Council, New Delhi.

Ford Foundation Study: Gender, Sex and Power, Implications of empowering women at risk to HIV, India, Draft report, CARE India, 2009

7	In case of police violence	56	62		
8	In case of any kind of violence (including household)				30
D	Collectivization				
1	I feel a collective identity with sex workers I do not know	71	76		74
2	Gone for public events where one could be identified as a sex worker (ever)	34	57		
3	Gone for public events where one could be identified as a sex worker (in the last six months)				47
E	Exposure to the SAKSHAM program				
	No exposure	70	46		19
	Exposed	30	54		81
F	Treatment for STIs				
1	Treatment sought for STI symptoms within 7 days or less	82	94		
2	Treatment sought for STI symptoms in the last six months				94
G	Where was treatment sought				
1	Where was treatment sought for STIs				
	SAKSHAM clinic	10	41		83
	Private	38	29		10
	Govt	33	21		7
	RMP	19	7		
2	Where was treatment sought for Reproductive health				
	SAKSHAM clinic			50	
	Traditional healers/RMP			87	
	Govt			30	
H	Condom Utilization last sex act				
	Occasional client	78	90		

	Regular client	74	87		
	With all clients (in last 24 hours)				90
	Lover	51	58		40 (n=111)
	Husband	12	17		16* (n=18)
	*Base numbers low				
I	Condom use last six months (always)				
	Clients			97	88
	Lovers			34	40 (n=111)
	Husbands			26	3*
	*Base numbers low				
J	Respondents convinced at least one client who did not want to use condom in last six months	58	73		
K	HIV test				
	Taken HIV test			70	70
	Received HIV report			70	70

Annex 5. Mid-term Review Recommendations and Changes made over two years

MTR Recommendations	Changes (March 2007- Present)
Outreach clinic needs to be strengthened	Strengthened substantially. Outreach clinics has been strengthened. There is regular schedule of mobile clinics based on need and availability and on fixed days approximately 13.25 clinics per month (Dec 06 – Mar 09). The outreach clinic schedule is posted well in advance (one month) and is planned in consultation with the communities. Clinics are held twice a month in all CBO areas.
Determine population to be covered by outreach. Develop plan on how they will access services through SCAs	SCA wise KP physical counts conducted, SCA wise map of KP available. However, due to secret and home based nature of sex work and also seasonal and contractual migration outreach is still not up to expected level. SCAs records record only registered members. Need to strategies further including meticulous monitoring the field team
Embedded DIC clinic in different locations provide fixed time schedules	The community Health committee (Arogya Brindum) completes scheduling based on need and season
Analyze data from provision of clinic services.	Data analysis explained to Arogya Brindum on a monthly basis. It is also taken as one agenda point in the CBO and Naari SAKSHAM executive body meetings.
Find 'non-users' who have been one-time users.	Not been done very regularly. It is hoped that the CBMS software tracking will be easier. However, it is complex and will require expertise that may be difficult to get in NARI Saksham.
Indepth analysis on why only 14% of the monthly risky sexual acts are covered	The coverage has now increased as seen in the STI trends analysis. . Specifically, while the percentage of risky sexual acts covered should be 33%, it has increased to 28% from 14% (in 2007.
Systematically track and promote STI treatment utilization.	Software addresses this concern, but only in part since the software is complex. SCAs and Arogya Brundam members need to track these more systematically.
Plan for scaling up service utilization	As a result of planning only the mobile clinics have increased three times and now the PHC linkages are getting strengthened
Community Mobilization	
Institutionalizing CIT within the CBO must be better understood and articulated	. All CITs are not equally strong but the central project level CIT is very strong. CIT members in CBOs were taken for exposure to Bangalore to study crisis response.
CB for GMS increased to improve 'transactions with constituencies"	Due to internal community and NGO dynamics expected results could not be achieved. Only one CB on electoral process could be conducted.
Integrate portfolio to government officer who plays coordinator role so it's	The position has been discontinued

part of his/her job	
Need for a technical person in immersion site (not just training officer)	The immersion program's major focus has been community mobilization, not as a HIV public health person.
Include wing positions in the organogram	It is included but not as part of SAKSHAM organogram because they are Naari SAKSHAM employees and not SAKSHAM employees
Training calendar for the staff with pre-identified trainings needs	A training calendar for the staff is not available, based on need. Training is not uniform However, staff were given training in Team building, counseling, NACP III TI guidelines, Monitoring, Magnet theatre etc.
Adherence to "one person one job"	SCAs, ORWs, CCs do not hold other positions. SAKSHAM is reviewing the practicality of this policy since there are not many literate community leaders in Naari SAKSHAM
Clear ORW reporting line; transparent clear way which prepares ORWs to take over FO or DO	According to CARE, educational limitations does not allow community members to assume FO and DO level responsibilities. Instead, they are assuming coordination level responsibilities such as Out Reach Coordinators, and sub committee Coordinators. More role clarity between FO/DO responsibilities is necessary.
Training coordinator to be gender sensitive, understand CLSI, and document the key learnings the visiting team takes back, learnings should be shared with project team.	The former training coordinator has been removed. The present one is gender sensitive and highly appreciated. Documentation of key learnings has substantially improved over the past two years . Findings are shared on a monthly basis among all project staff. Training Coordinator should visit the field on a regular basis to streamline learning.
Program manager should have more autonomy and held accountable to bench marks	While a new manager is in place, this continues to be a concern. During the second phase, CARE plans to locate management in Rajhamundary and Hyderabad.
Finalized manuals and tolls on HR management	CARE's DISHA guidelines are one of the most comprehensive HR manuals available. It is available online to all CARE staff.
Tools and modules finalized and utilized	Tools and modules are now finalized with most printed. long and drawn out approval and finalization processes prevented staff to utilize tools on the ground during phase I.
Strengthen the learning site by having a decentralized approach and high quality technical assistance	Technical assistance was given to the learning site in terms of making tailor made circuits, content specific modules, follow up planning, feed back consolidation and establishment of CLSI resource center. The site was also marketed at NACO and different SACS officials. As a result, several TSUs (CARE and non CARE) visited together with implementing partners.
Promote learning site as the flagship to the SLP with	Over the last two years, special efforts were made to involve SLPs from AP to visit the learning site. In

proactive support from Avahan and have the agenda for assisting them to learn on areas of community mobilization, community based organization development and support, CBO federation development in the district and strengthening them	response, a number of HLFPPT-supported CBOs visited the learning sight. These were CBOs that were otherwise reluctant to visit. SAKSHAM has had to work against its negative reputation and is progressively gaining credibility among partners.
Develop newer and advanced curriculum and have it built in such a way that overall technical support is provided as a continuum and not a one stop education at the learning site itself	Follow-up plans, action plan, and feedback-learning mechanisms have been incorporated in the immersion program. CARE developed a cadre of 10 community consultants who provide field support to CBO members. Tailor-made support was provided: ORCHID, CBO representatives (60) from TAI, ALLIANCE and HLFPPT. CB support is planned for several subjects such as: leadership, CBO management, transition, communication, power analysis, and building self esteem.
Develop Technical Assistance and Support process for the SLP/IP and CBO at the State Level by apportioning budgets for each SLP, based on the joint plan as agreed by Avahan, SLP and CARE.	Due to a strategic shift CARE had to withdraw state managers and graftees from the field which resulted in CARE's absence among SLPs. Avahan took up the responsibility of coordination.
Promote institutional mechanisms including TA delivery system (e.g. Graftee System, Local CLCAB etc) and make sure that the TA is interconnected and not isolated	Both the systems were withdrawn. Under bucket-funding based on Avahan's recommendation CARE has provided TA to southern states through various consultancies including support to ORCHID through consultancies.
Develop specific institutional mechanism that is suitable for North-East and have north east conversant professionals and community assisting this process	An additional fund was given to EHA for establishing a learning site for IDU in Manipur. CARE supported them by facilitating a three-day workshop for re-orienting the NGO partners in CLSI. Meetings were also held with ORCHID to strengthen the partnership by inducting their finance and administration team into CARE systems.
More focus on service utilization (condom and STI services)	In the past two years linkages have been established with different PHCs to improve services. Through a clinic – outreach linkage model, through SCA and with support from Arogya Brundum CARE has tried to ensure maximum utilization of available services.

	Home-based (secret) sex workers who get condoms from the SCA never come to the clinic. This number is reflected in the (outreach) project report but does not get reflected in the clinical database. Similarly, there are those who come from outside the target area and avail clinic services. These cases get a place in the clinical database but never get reflected in the outreach data. Efforts are being made to capture these by way of health card tracking and registers being maintained at PHCs, ICTC, and DOTs centre.
Focus on monitoring	Monitoring needs improvement, in part because of the need to clarify roles between field- and demonstration-officers. Officers do not appear to be familiar with the data generated and entered into the reporting systems. CARE has attempted to put clinical database systems and outreach data (CBMS) together. They tried to establish synergy between these data and Avahan CMIS. CARE staff (presumably from Delhi) physically verifies data once in 6 months. This approach helped in covering almost double the number of sex workers than earlier.
PD/ OM new and with management background – How to address the technical gap in the team?	The PD position was removed. The OM became the team leader with overall guidance by the ACD with strong HIV technical expertise. The OM has received support from the technical specialist and the Monitoring and Documentation manager. Other technical experts, such as Dr. Mitra, provided support. More technical experts could have provided needed expertise in the new technical areas showcased in SAKSHAM.
Graduation plan is required for transition of project to NS	Transition design is in place but a detailed transition plan with clear indicators needs to be developed. There is little clarity, about transition, among CBO partners
The leadership across levels has to be techno – managerial in nature	Promising leadership capacities are demonstrated through the wing positions and leaders of CBOs, community led interventions and Nari Saksham. Managerial and financial skills are lacking.
Managerial reform and technical capacity building was proposed	The overall management design and entire team changed. Team members were sent to trainings and capacity building exercises to learn a variety of managerial skills (List of CB and exposure visit is available)
Decentralization of systems at Rajahmundry level	Much of the project was managed from Delhi. The second phase will be managed out of Rajhamundary and Hyderabad.
Community resources to prepare for future programming	Human resources includes: SCA, Com. Consultants, Crisis Intervention Team, Com. Led Initiatives, Executive Committee, Core committee, Project manage committee, and Wing positions. Financial resources have not been forthcoming.

To introduce shadow positions for a smooth transition	Wing position were introduced, but delayed.
The outreach clinic needs to be strengthened. The population should be covered by outreach should be determined. A plan should be designed on "how they will access clinical services periodically" through the efforts of SCA should be conceived.	Over the past two years, Arogya Brundum has made plans for a mobile clinic, based on demand. Clinic-based staff conduct outreach relying on lists of those due for regular check ups. However, tracking and follow up needs further strengthening. Mobile clinics take place but not during set schedules. Rather, clinics are scheduled based on needs as they arise which is determined by Arogya Brindum. Clinic times are linked to CBO meeting times.
More involvement of RM staffs in decision making	Decision making, budget allocation process and annual plan development are done in the annual action plan workshop in Rajhamundary. In addition to CARE staff, community leaders and Naari SAKSHAM staff are integral part of this workshop. Nonetheless, there is still some concern that more decision-making should like in the hands of RM staff and communities. For this reason, phase two will be led out of the RM and Hyderabad offices.
Gender balance in the team, since it has been a project specifically targeting women	There has been some improvement in the female-to-male staffing ratio. Though there are still far more men in high positions which are based in Delhi. In 2009 CARE ensured that the PM position would be a woman from AP. It is difficult to recruit for positions that are based in Rajamundary.

Annex 6. Quotes from on Immersion event experiences

The following quotes were drawn from interviews with SACS, NGOs, and CBOs

I liked going to SAKSHAM, [over the other site], since it's more program focused. SAKSHAM is concerned about HIV/AIDS.

In Nari Saksham and GMS there is equal collaboration with other CBOs. They don't' dominate. This is a very important and useful for the community.

I don't feel there is dominance in Rajamundary. The power has been distributed equally. It's more of a democratic process.

We learned so many things… They have important role in our project. The peer led approach. There is a community led approach.

One thing that touched my heart is their grain bank. They are equally distrusting food to needy sex workers. In Delhi, now I have started the same program.

What I have learned… there is a strong advocacy system. At the outset they did a very strong stakeholder analysis. Now I have started to do the stakeholder analysis.. the hotel and tea stall..

Their clinical set up is really fantastic. They have an observation room. Whatever apparatus is there, everything is in the right place.

Counseling is important in each and every project they do there. The community people themselves are the counselors. They aren't just talking about issues of HIV, but also counseling of the mobile clinic; and other things like nutrition, a balanced diet.

How to form a CBO wasn't very clear for us, before we went [to Rajhamundhry]. The concept of NGO transitioning a CBO wasn't there, with us, before. We got such clarity form the CBOs… all the nittie gritties... We got an idea the steps and how to do those steps.

We saw the wing positions in SAKSHAM: the ones in CARE are the same ones in the community. It's like hand-holding, helping them out; building capacity. They learn how to manage and how to run independently.

Initially when we talked about a CBO development it was a threat to NGOs, but what we saw is that SAKSHAM doesn't lose itself. They told us this… and we saw it. No matter what, they still pass on responsibility to the CBOs.

We made an action plan. This has made huge difference in day to day. I replicated many things-- the grain bank… and stakeholder analysis… then implementing the same. We are becoming more systematic. We were not doing it systematically with timelines, priorities and steps for our work. With their help, everything we saw, now we are.

Sex workers there, in Rajhamundary, are very much empowered… so vocal. They have no hesitation. In Delhi they are not so vocal.

After returning, we formed a CIT… with DIC and clinical services. At later stage we will take it further bringing committees together and forming a GMS.

Before we didn't have a clear concept... Before I thought there was no way you could turn over project to sex workers, not based in brothels, since they are hidden population. We saw that they are doing it.

SAKSHAM is more approachable to the community. SAKSHAM took care of small points in service delivery… such as privacy, treatment, disposable needles, more clean… sensitivities of client population. Privacy was a big thing.

SAKSHAM is more professional than other sites we visited.

Our main objective was to focus on how to transition, looking at the processes and systems. We saw what was needed and everything we expected came in the visit.

Outreach… They are having a soft system. If people from community move, she is tracked and if she wants services she can be tracked out. That we don't have but we have learned. It's cost effective.

Documentation... Everything was displayed – small reports. Displayed. Everything was good. They displayed our micro-level planning. Each and every activity. Everything is displayed, written down.