

Prevention of HIV and AIDS & Care for People Living with HIV and AIDS

**A Toolkit for
Program Managers
- Karnataka Health
Promotion Trust**

This toolkit has been made possible by the generous support of the United States Agency for International Development

Guiding Principles

- Be evidence based
- Address gender issues
- Leverage and coordinate resources
- Link with the national and state HIV and AIDS program
- Mainstream involvement of PLHIV
- Build local capacity
- Document and disseminate innovations and lessons

Communication Strategy

- Know your target audience: create messages based on thorough consumer research.
- Keep it simple: keep communication messages discrete, clear and simple.
- Don't preach...engage: ensure that target audiences spend time considering issues and facilitate discussion rather than just provide information.
- Once is never enough: ensure repeated and consistent exposure to the same message.
- Make it fun: it is important to entertain and educate target audiences.
- Make it fresh: innovative materials to assist on ground communicators are important.
- It's all about people: motivated and energetic staff are key. Invest in them.
- Professionalize the team: frequent training of field and on-ground support and supervision are essential.
- Monitor impact regularly: track actual impact and fine-tune interventions.
- Systems are important: need good management systems to support complex and dynamic programming.

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THIS TOOLKIT

This is a toolkit to guide the management and implementation of HIV prevention and care programs for general populations, sex workers, people living with HIV and AIDS and orphan and vulnerable children in rural Karnataka. It is for use by program managers of Karnataka Health Promotion Trust responsible for the implementation of project Samastha, a joint initiative of the University of Manitoba, Karnataka Health Promotion Trust and the USAID for scaling up HIV Prevention in Karnataka and Andhra Pradesh. The project seeks to:

“Develop a comprehensive program that provides HIV and AIDS prevention, care, support and treatment to vulnerable and affected populations in 12 high prevalence districts in Karnataka and in four coastal districts in Andhra Pradesh”.

This toolkit seeks to provide an overview of the strategic framework for effective implementation of integrated HIV prevention and care programs in rural areas.

The toolkit is organized into 3 parts, one for each of the specific target groups. Each part includes information on the need for the specific component and the importance of the target groups therein; strategies and components of the program; and information on how gender concerns can be integrated into programs. Each part concludes with a checklist.

INSIDE

This toolkit is organized into 3 parts:

I. Prevention of HIV and AIDS among general population;

Target groups:

- Pregnant women
- At risk men
- At risk women

II. Prevention of HIV and AIDS among rural female sex workers

Target groups:

- Female Sex Workers (FSW)
- Lovers and regular partners of FSWs

III. Care for people living with HIV and AIDS.

Target groups:

- PLHIV and their families
- Orphan and vulnerable children (OVC)
- Patients/ Suspects of Tuberculosis (TB)

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I. Preventing HIV and AIDS: General Population in the Rural Area

Why Address General Population?

The HIV epidemic in Karnataka has reached rural areas and there is substantial risk and vulnerability in rural areas that could further amplify the epidemic. More than half of the PLHIV live in rural areas and HIV prevalence among rural women exceeds that for urban women in at least half of the districts in Karnataka. Eventhough there is limited transmission of HIV within non-commercial partnerships (especially in the majority of the southern Karnataka districts) and a large percentage of HIV infections among men are attributed to being a client of a sex worker, high HIV prevalence among clients makes it necessary to do HIV prevention work with the general population (including wives and partners of these men). There are districts in the northern part of Kanataka where HIV prevalence among clients is higher than 6 per cent. In those districts, such clients become bridge populations and increase the possibility of infecting their wives and other sexual partners. In some of these districts there is also evidence of sexual networks extending beyond commercial sex. Hence, in those districts there is a need to focus prevention efforts among general population, especially men and women at risk. There is also need to work with pregnant women in the rural areas, in order to ensure prevention of mother to child transmission.

Decrease in HIV prevalence among general population is an indicator of decrease in number of people becoming newly infected with HIV. Hence, covering the general population, especially women and men at risk and pregnant women, in rural areas, is critical for the effective prevention of HIV and AIDS in Karnataka.

It is necessary to do HIV prevention work among general population, in districts where HIV prevalence among clients of sex workers is high, to prevent transmission of HIV from this bridge population to others

Who Are The Target Groups?

Pregnant women:

- Women who are currently pregnant.
- Pregnant women who are tested HIV positive.
- HIV positive mothers and their children up to 18 months.

At risk men:

- Men who are clients of FSWs.
- Men who have multiple female partners other than FSWs.
- Men who have experienced symptoms of Sexually Transmitted Infections.
- Men who have anal sex with other men.

At risk women

- Women who have non-commercial multiple partners.
- Women who have experienced symptoms of Sexually Transmitted Infections.
- Wives of men who are clients of FSWs.
- Wives of men who have multiple female partners other than FSWs.
- Wives of men who have anal sex with other men.
- Wives of men who have experienced symptoms of Sexually Transmitted Infections.

What Outcomes Are Expected From these Efforts?

- Increased correct knowledge and decreased misconception of HIV transmission and prevention among target groups.
- Reduced level of high-risk sexual behavior among target groups.
 - Early and complete treatment of STI.
 - Fewer sexual partners.
 - Correct and consistent use of condoms in every risky sexual encounter.
 - Increased access to and use of HIV testing services in ICTC.
- Increased gender equity and reduced gender based violence.
- Increased positive attitudes towards PLHIV, FSWs, OVC among general population in the village.

- Increased access to and use of HIV testing and care services by pregnant women.
 - Pregnant women tested for HIV and obtained results.
 - Positive pregnant women given Nevarapine at the time of delivery and registered for ART.
 - Positive mothers follow safe feeding practices up to 18 months.
- Increased ownership/ volunteerism for the project in the village.

What Are The Key Strategies?

- **Reaching most at risk population:** Reaching everyone among the general population is neither possible nor useful. Hence, the strategy is to do a risk assessment of the population to identify those most at risk and work intensively with them. Communities are approached through participatory tools such as social mapping, focus mapping and resource mapping that identify most at risk populations and resources that could be utilized for intervention (see above for list of most at risk men and women). However, engagement and involvement of communities and key informants within the community (such as Anganwadi worker, ANM, school teacher, PHC doctor, etc.) is essential to identify the most at risk population.
- **Communicating for behavior change:** Behavior change communication has proved to be the most effective method to reduce risky behaviors and prevent HIV among those at risk. Those most at risk are targeted with intensive behavior change communication through IEC materials, one to one meetings and group meetings.
- **Engaging people in a process of reflection:** Stepping Stones are used as a tool to engage men and women in a process of reflection to understand factors that contribute to their risk and vulnerability to HIV. Skills of men and women are built so they can reduce their risks and vulnerabilities. Factors such as gender norms, traditional/ cultural practices that make people vulnerable to HIV are discussed with

the community members and local solutions are explored to address them. See box on Stepping Stones.

What is the Stepping Stones?

Stepping Stones module adapted, by KHPT in conjunction with ActionAid, to suit the Indian context is used as a mobilization and behavior change tool. This community tool is intended to improve communication skills, educate about healthy sexual lifestyles, and empower individuals and groups to influence the agendas and social norms within the community and also to reduce stigma and discrimination against positive people. This tool has been recognized by UNAIDS as best practice for community mobilization.

- **Increasing access to services and commodities:** General populations in rural areas have limited access to good quality health services and commodities such as condoms or disposable syringes and needles. The strategy is to strengthen capacities of local service providers so they can provide good quality services to the target groups without discriminating against them. Target groups are linked to these service providers by using formal system of linking (referral cards), tracked individually and followed up on. Condoms are made available at outlets that are non-threatening, non discriminating and accessible to both men and women. Those accessing services are encouraged to procure their own needles or syringes for injections or to demand for the same.

What Are The Key Program Components?

1. Situation Needs Assessment

Conduct assessments: Evidence based program planning and intervention requires as a first step, an assessment of the situation of HIV and AIDS among the general population. The assessment should lead to:

- Understanding of local social structures.
- Identification of resources and key organizations.

- Understanding of risk and vulnerability factors in the community.

For these assessments a variety of participatory tools are used, such as

- Transect Walk
- Social Map
- Segment Map
- Focus Map

These assessments should be done periodically. In addition, annual participatory program reflections and polling booth surveys should be conducted to track the behavioral outcomes.

2. Outreach

Introduce the project: General population in the village, formal and informal leaders and target groups need to be introduced to the project purpose and workers to build an environment of goodwill and support. Develop geographical and population based micro plans for outreach. Use folk media for wider reach and to introduce the link worker.

Educate: Conduct group sessions with different sub groups of men and women at risk (unmarried women/men, married women/men) for intensive behavior change. Use Stepping Stones as tools for educating and communicating. For pregnant women, make home visits and conduct one to one sessions. With all groups, make them aware of HIV, STI, counseling, testing and treatment. Educate on correct (through demonstration) and consistent use of condom.

Make Referrals: Counsel men and women at risk and refer them to STI clinics and ICTC services. Counsel pregnant women and their partners for testing in ICTC. Refer the partners and children of those testing HIV positive to ICTC. Those who test positive should be linked to care services. (See Section III).

3. Services

Make condoms available, accessible and normal: Establish at least 2 condom depots per village. Promote condoms in an attractive, non-stigmatized way, promoting their multiple advantages including contraception, hygiene

and prevention of STI, HIV and cancer. Make sure depot holders for condoms include males and females. Condom depots can be set up at paan shops, ration shops or with Anganwadi Workers or women leaders, etc.

Identify and build capacities of service centers/providers: Identify service centers accessed by men and women for regular health concerns. Prepare and train service providers for STI and HIV related services. Link them with government medical centers. Build capacities of existing health and ICDS infrastructure including ANMs, ASHA and Anganwadi workers.

Encourage health service seeking: Bring target groups, especially young people, and health workers together to brainstorm solutions to locally identified issues that prevent youth/ men and women from using services and assist facilities to implement solutions.

4. Enabling Environment

Use folk media: Use folk and local media to build an environment of acceptance of HIV and related issues in the community.

Develop mechanism for crisis response: Develop a district level crisis management system and link it with local communities through SS groups, clinics, schools, VHSCs, DAPCU, CBOs and NGOs. This system should help report and address any cases of stigmatization/ discrimination faced by any member of the community on account of his/ her risk and vulnerability status.

Train and develop community leaders: Identify supportive formal and informal leaders who can take on leadership roles to influence norms and behavior in the community.

5. Community Mobilization

Facilitate and strengthen Village Health and Sanitation Committees (VHSC): Facilitate regular meetings of VHSC, inform and engage them in their role in preventing HIV and taking care of HIV affected widows and children.

Develop change agents: Develop change agents from among SS groups who will then work to change behavioral norms in the community.

Encourage SS participants to become volunteers across different age groups and form Red Ribbon Clubs. Give volunteers specific roles in the project, for instance, for mobilizing community for events, distributing condoms, educating peers and so on, and acknowledge them.

- Focus on single/deserted women, orphans and adolescents
- Involve men AND women of all ages and caste groups in the situation needs assessments. Ensure young girls in particular participate.
- Husbands/ parents in law normally take family decision. Involve them in the change process.
- Create awareness about vulnerability of women and responsibility of men in relation to HIV.
- Involve both men and women in reflection and behavior change process
- Include reflection on gender issues and its link to vulnerability to HIV
- Challenge gender stereotypes that put one at risk to HIV
- Ensure there are safety and protection mechanism for women and girls who may face violence because of challenging gender relations
- Address other fears and responsibility related to pregnancy with the couple.

Checklist I. Preventing HIV and AIDS: General Population in the Rural Areas

Program Component		Target Groups: At Risk Men and Women and Pregnant Women
1	Situation Needs Assessment	<p>1. Conduct Transect Walk and develop Social Map, Segment Map to understand the villages and develop Focus Map to identify at risk men and women and pregnant women.</p> <p>2. Update maps regularly, especially the Focus Map for all target groups, especially pregnant women</p>
2	Gender Integration	<p>1. Involve men and women across age 2. Ensure members of different caste groups are available in developing these maps 3. Ensure the maps are developed with women specially if their participation is low 4. Ensure young girls are involved proactively.</p>
2	Outreach	Pregnant Women
2a	Build rapport and get entry into the village	At Risk Men and Women
2a		<p>1. Organise entry level programmes/ kalajatha/ folk shows and visit households in each segment of the village to introduce the project and purpose</p> <p>2. Meet the village leaders (formal and informal) to introduce the project and the link workers</p> <p>3. Focus on and build rapport with at risk men and women identified in the Focused Map.</p>
2a	Gender Integration	At Risk Men and Women
2a		<p>1. Involve husbands/ parents in law of the pregnant women who normally take family decisions 2. Include topics like vulnerability of women, responsibility of men in the context of HIV in the communication programmes/ events 3. Avoid communication like “sex workers are vectors” that promote stereotypes 4. Focus on single women, deserted women and orphans.</p>
2b	Conduct focus sessions	At Risk Men and Women
2b		<p>1. Motivate and build rapport with at risk men and women identified through focused maps to form groups (SS)</p> <p>2. Initiate and follow through stepping stones sessions with groups of boys, men, girls and women</p> <p>3. Sustain the groups after the sessions have been completed by developing the members as volunteers</p> <p>4. Form Red Ribbon Clubs as an outcome of doing SS sessions with young men and women</p> <p>5. Follow up with the groups once a month to sustain the change process</p>
2b	Gender Integration	Pregnant Women
2b		<p>1. Motivate and build rapport with pregnant women and their families identified through focused maps to participate in the programme and register pregnant women into the programme.</p> <p>2. Meet the women and their families in their homes and counsel them to test for ICTC</p> <p>3. Conduct events for pregnant women to give them general information on care for themselves and the child, including HIV testing.</p> <p>4. Follow up with the pregnant women</p>
2c	Referral to STI	At Risk Men and Women
2c		<p>1. Involve both men and women in reflection and behavior change process 2. Include reflection on gender issues and its link to vulnerability to HIV 3. Involve couples/ family members in the change process 4. Challenge gender stereotypes that put one at risk to HIV 5. Ensure there are safety and protection mechanism for women and girls who may face violence because of challenging gender relations</p>
2c	Referral to STI	Pregnant Women
2c		<p>1. Educate at risk men and women particularly members of SS groups on STI symptoms</p> <p>2. Refer people with STI symptoms for treatment</p> <p>3. Follow up to ensure if the treatment has been completed and counsel partner to go for check up.</p> <p>4. Promote condom use for all risky sexual contacts</p> <p>5. Follow up after 6 months to check for symptoms</p>
2d	Gender Integration	At Risk Men and Women
2d		<p>1. Ensure partner treatment is complete 2. Support women to convince their partners for treatment</p>
2d	Referral to ICTC/PP/TCT	At Risk Men and Women
2d		<p>1. Refer all at risk men and women particularly members of SS groups to ICTC and follow up. Refer all pregnant women to ICTC/PP/TCT and follow up</p> <p>2. If found positive, link up with care services (outlined in care framework Checklist III)</p>
2e	Gender Integration	At Risk Men and Women
2e		<p>1. Offer services of female counselor if needed. 2. Motivate for partner counseling and testing 3. Address other fears and responsibility related to pregnancy with the couple</p>
2e	Promote condom use	At Risk Men and Women
2e		<p>1. Educate the target groups on the multiple benefits of condoms, types of condoms available and where they are available</p> <p>2. Distribute condoms to at risk men and women particularly members of SS groups, pregnant women and their partners/ husbands, counsel and demonstrate on correct and consistent use of condoms .</p> <p>3. Build skills for negotiating use of condoms with sexual partners.</p> <p>4. Follow up</p>

	Gender Integration	1. Build skills of women to negotiate condoms 2. Make condom use a norm among men 3. Support women to motivate their partners to use condoms 4. Understand barriers to access and use of condoms by men and women and address them.
3	Services	
3a	Access and Availability of Condoms	<ol style="list-style-type: none"> 1. Identify condom depots in the villages from where the at risk men and women and pregnant women can access condoms and ensure that condom availability by regular refilling as per need 2. Train the condom depot holders on correct and consistent use of condoms (demonstrate regularly) 3. Directly distribute condoms through link workers.
	Gender Integration	Ensure that condom depot holders include men as well as women.
3b	Set up STI services	<ol style="list-style-type: none"> 1. Identify preferred providers accessed by at risk men and women and pregnant women for medical services. 2. Train and prepare the centers to provide STI services. 3. Develop referral linkages with government health centres. 4. Develop linkages with specialist to provide specialist services if required.
	Gender Integration	1. Identify and train female doctors as referral doctors 2. Develop access point closer to homes specially for women 3. Ensure privacy, confidentiality in the clinics
4	Enabling Environment	
4a	Advocacy within the village	<ol style="list-style-type: none"> 1. Regularly meet and update formal and informal leaders and health care providers on the progress of the project 2. Sensitize the leaders on HIV issues and seek their support 3. Develop supportive leaders from among existing leaders who can take leadership roles in the project 4. Ensure Link workers participate in other government initiatives like pulse polio etc in the village 5. Meet with ANM, AWW, ASHA, discuss about the project and train them at least once in 6 months 6. Train the leaders within the village at least once in 6 months
	Gender Integration	1. Include women leaders and make them advocates 2. Include sessions on gender and HIV in the training 3. Reflect on role of leaders on making lives of men and women safe
4b	Linkages to Crisis response	<ol style="list-style-type: none"> 1. Develop a system in the district to address stigma and discrimination/ crisis issues 2. Inform the population through clinics, SS groups, outreach etc about this system and the services it provides. 3. Support men and women who face S&D issues, build understanding on their rights, entitlements and the law and provide counseling support wherever needed 4. Document cases of discrimination and action taken in crisis and provide legal support wherever required. 5. Mobilize support from family, VHSCs, School, Networks/ CBOs, DAPCU 6. Establish linkages with other organizations and institutions for support.
	Gender Integration	1. Women face double stigma and hence their needs will be prioritized. 2. Proactive legal support to women and orphans on issues of inheritance, property and guardianship. 3. Sensitize community on stigma and discrimination faced by women, girls, MARPS within the family and outside
4c	Advocacy with district officials	1. Meet the DAPCU officer regularly, send progress reports and follow up.
	Gender Integration	1. Sensitize the district officials on gender issues
4d	Facilitate and Strengthen VHSC	<ol style="list-style-type: none"> 1. Facilitate formation of VHSC as per NRHM norms and federate of needed. 2. Facilitate regular meetings of the VHSC and train them on their role and on HIV 3. Strengthen VHSC by giving a role in the project and/or responsibility for some programme components of the project 4. Advocate with VHSC to allocate funds to run HIV programme 5. Strengthen VHSC by helping them address structural issues in the village like education, primary health care, water and sanitation, child marriage, dowry etc 5. Follow up and support.
	Gender Integration	1. Ensure there is representation of women in the VHSC 2. Train the VHSC members on gender issues 3. Ensure VHSC takes up issues of vulnerable women and support them 4. Issues of gender based violence are addressed in the VHSC
5	Community Mobilization	
5a	Develop volunteer base	<ol style="list-style-type: none"> 1. Encourage the SS members and pregnant women to become volunteers of the programme, give them specific roles and responsibilities in implementing specific programme activities. 2. Give a specific role to the Red Ribbon clubs 3. Develop positive speakers and acknowledge them and other volunteers publicly
	Gender Integration	1. Include women as volunteers

II. Preventing HIV and AIDS: Rural Female Sex Workers

Why Address Rural Female Sex Workers?

There are 3 interrelated reasons why it is necessary to work with Female Sex Workers (FSWs) in the rural areas. Firstly, substantial populations of FSWs work in rural areas - more than half (54 percent) of FSWs in Karnataka and up to 85 percent in some of KHPT project districts, live and practice sex work in the rural areas. Secondly, HIV prevalence is much higher among FSWs (10-20 per cent) than other populations and a few sex workers would have more sexual encounters than many monogamous women in the general population. Prevalence of concurrent STI among FSWs would increase substantially the risk of HIV transmission. Thirdly, almost all HIV infections in the target rural areas can be attributed to sex work and to sexual networks - virtually all HIV infections among women in the rural areas in this project are accounted for by infections among FSWs and primary sex partners of their male clients. Also, most infections among men are accounted for by infections among male clients of FSWs and men having sex with men. FSWs, their clients and non commercial partners (lovers) form important high risk sexual networks in rural areas. They are important in expanding the size of local epidemics, making rural sex work important in rural HIV transmission dynamics. KHPT's experience has shown that effective interventions with FSWs have the potential for stabilizing the epidemic.

It is important to work with rural FSWs because the HIV epidemic in Karnataka is sex work driven and substantial proportions of FSWs in Karnataka live and work in rural areas. KHPT's experience has shown that effective interventions with FSWs can halt the HIV epidemic

Who Are The Target Groups?

Female Sex Workers:

- Women who sell sex and live and practice sex work in the village
- Women who sell sex and live in the village but practice sex work outside the village

Lovers and partners of FSWs:

- Lovers are main male non-commercial sexual partner not married to the FSW, living in the village or outside

FSWs are further categorized, based on their age (young/ old), client volume (high, medium, low) and duration in sex work, for specific interventions since all these factors have differing levels of risks and vulnerability.

What Outcomes Are Expected From These Efforts?

- Increased correct and consistent condom use with clients and lovers/partners.
- Early diagnosis and treatment of STI among target group.
- Increased access to and use of HIV-related services, including ICTC among the target group.
- Increased access to and use of HIV care services by HIV positive target group.
- Increased membership and participation in a CBO of FSWs in the district.

What Are The Key Strategies?

The strategic framework for preventing HIV and AIDS among FSWs includes

- Risk reduction: Risk reduction strategies include: providing correct knowledge about STI and HIV prevention; having a differential outreach plan based on risk and ensuring total coverage; promoting condoms and lubricants; and ensuring access to health services for treatment of STI and other related health problems.
- Vulnerability reduction: Vulnerability reduction strategies include: facilitating awareness and access to basic human rights and social entitlements through provision of basic amenities; sensitizing key players both in the sex work circuit and wider community; building supportive environments, such as crisis response teams, and advocating with government representatives for attitudinal change and greater understanding of the groups' vulnerable to HIV and laws that govern

sex work; and building a sense of common identity and common purpose leading to participation and ownership of HIV issues.

What Are The Key Program Components?

1. Assessments

Understand and respond to community needs: Given the guiding principles of being evidence-based and participatory in KHPT programming, it is important to consult with FSWs on an on-going basis to identify needs and responses collectively. FSWs across different age groups, settings and client volumes should be represented in such consultations.

2. Community led outreach

Ensure high levels of coverage: High level of coverage is important for two reasons: firstly, it is necessary to halt HIV transmission and secondly, once presence of sex workers in a certain location is known, it becomes a moral responsibility to ensure that they have access to services and information.

Differentiate outreach efforts: Not all FSWs are at the same level of risk and vulnerability and hence efforts should be differentiated with differing needs and situation of FSWs. Classification is based on volume of clients, age and duration in sex work and outreach should be convenient to the FSW as well.

Provide comprehensive knowledge and skills for preventing STI/ HIV and AIDS: Interpersonal or group communication that builds information and skills, on condom use and negotiation with partners/ clients and preventing and treating HIV and STI, are critical in helping FSWs protect themselves. Meet the lovers and partners of FSWs and provide complete and comprehensive information related to HIV and AIDS.

3. Access and linkages to commodities and services:

Ensure availability and promote correct use of condoms: One of the main responsibilities of outreach teams is to ensure that condoms and lubricants are available to all populations that

are at highest risk. Identify appropriate condom outlets and ensure that outlets are equipped with condoms at all times. Also distribute condoms directly through peers and volunteers.

Provide access to services: Make services accessible through referral and build capacity of local service providers so that FSWs can access quality health services and VCTC, without being discriminated against. Ensure that the lovers and regular partners of FSWs access STI and HIV testing services regularly.

4. Enabling Environment

Sensitize key influencers: Identify and sensitize key influencers in the sex work circuit including lovers and brothel madams, pimps, agents, etc. Organize regular programs for their sensitization.

Sensitize local institutions and service providers: Identify and sensitize local institutions such as VHSC and service providers such as Anganwadi workers and ANM about FSWs. Sensitize health care providers such that they do not discriminate or stigmatize FSWs.

Provide linkages for rights and entitlements: FSWs have needs other than those directly related to their risk to STI and HIV. These could include availability of entitlements (such as Voter ID, ration cards, housing, etc), schooling for their children and so on. These needs must be understood and plans for addressing them must be made in consultation with the FSWs by mobilizing local resources, linking with government/ non-government schemes and programs.

Develop crisis response system: Build FSWs' understanding of their rights, entitlements and the law. Facilitate development of a crisis management team and mechanism and train the team members in responding to crisis. Provide legal support as and when required and foster linkages with other organisations and institutions.

Advocate with district officials: Build rapport with district officials; sensitize them on gender and sex work issues. Meet them regularly and share progress of the project with them. Make sure sex workers are included in the DAC as members and

train them to advocate with DAPCU, DAC and other government departments for addressing the specific issues of FSWs.

5. Community Mobilization

Facilitate critical thinking: Facilitate FSWs to develop a critical understanding of gender, sex work and their rights and encourage them to form into support groups. Use SS as a tool and identify if the groups need to initiate savings and develop a plan to support that interest.

Facilitate collective action: Identify, in consultation with FSWs, activities in the project that they could implement collectively. Encourage them to become part of existing community based organisations.

Institutionalize collective action: Mobilize FSWs to form community-based organisations and encourage linkages between community-based organisations at taluk and district levels by federating them. Help them identify issues for collective action and support in the execution of those actions. Ensure elections to key positions within these organisations at all levels and train office bearers on management and governance. Regularly support these organisations and assess them on their progress.

- Involve sex workers across age group and typology in programs and plan outreach based on age, typology of the sex workers.

- Involve FSWs as peers to conduct outreach.
- Ensure lovers/regular partners are involved in critical thinking; understand their responsibility towards and the need to respect their sex work partner.
- Understand barriers to access and use of condoms by FSWs and their clients and build skills of the FSW to negotiate condoms with clients and regular partners/lovers.
- Motivate for partner counseling and testing.
- Understand barriers to access, care and treatment services by FSWs and address them.
- Identify other health needs (e.g. reproductive and sexual health) of the sex workers and their partners as a couple and provide services for that either directly or through referral.
- Make available/ accessible, counseling/legal services in relation to rape, violence, forced sex etc. to the sex worker.
- Give priority to vulnerable sex workers (FSWs with no support, FSWs with young vulnerable daughters).
- Ensure legal support for FSWs to resolve crisis related to family, property, violence, abuse, etc.
- Acknowledge the potential for violence, abandonment and other negative outcomes that FSW may face in taking collective action and support interventions to prevent/mitigate such situations.

Checklist II. Preventing HIV and AIDS: Female Sex Workers	
	Program Component
	Target: Rural Female Sex Workers and their lovers and partners of Female Sex Workers.
1	Assessments
1a	Understand and respond to community needs
	1. Conduct periodic discussions with the FSWs to assess needs of the community and respond accordingly.
	Gender Integration
	1. Involvement of sex workers across age group and typology in these discussions. 2. Include issues related to gender inequality, decision-making ability, gender based violence in the discussions.
2	Community led outreach
2a	Ensuring Total Coverage
	1. Identify the HCV FSWs through micro planning of clusters/ sites 2. Register all HCV FSWs and ensure regular contact (once in 15 days). 3. Ensure regular provision of condoms as per need and ensure visit to the clinic once in a quarter 4. Motivate the HCV FSWs for testing syphilis and follow up for treatment if positive at least once a year. 5. Organize special programs for FSWs who have lovers and their lovers 6. Ensure the lovers visit the clinic once in 6 months
	Gender Integration
	1. Involvement of female sex workers as peers to conduct outreach. 2. Plan outreach based on age, typology of the sex workers. Age and typology specific needs should be kept in mind while planning outreach 3. Ensure lovers/regular partners are involved in critical thinking, their responsibility and need to respect for their sex work partner
2b	Providing comprehensive knowledge and skills on STI, HIV and AIDS
	1. Use BCC materials and conduct one to one and one to group sessions. 2. Conduct SS sessions wherever feasible with high volume and young and new sex workers. 3. Demonstrate and re-demonstrate correct use of Condom.
	Gender Integration
	1. Discuss gender related inequality causing vulnerability in these sessions. 2. Build skills of the FSWs to negotiate condoms with clients and regular partners/lovers. 3. Meet lovers/conduct regular partners' meetings to discuss their responsibility in safe sex.
2c	Referral to PPTCT
	1. Identify pregnant FSWs and refer them to PPTCT. 2. Counsel pregnant FSWs, spouse and family on infant feeding practices and need for institutional delivery. Motivate couple for institutional delivery. 3. Follow-up of both HIV positive mothers to link them to care (CD4 testing, ART registration). 4. Follow up with the child of HIV positive mother for 18 months and link the child with care if found positive
	Gender Integration
	1. Offer services of female counselor if needed. 2. Motivate for couple counseling and testing. 3. Ensure children get tested and positive children get linked with care
2d	Referral to care services
	1. Refer positive FSWs to pre ART centre and to IPPCC for registration and support. 2. Follow up (review care package for other services). 3. Get positive speakers to address FSWs, talk about positive living. 4. Discuss cases of positive FSWs and draw up a plan of how they/their children can be helped.
	Gender Integration
	1. Offer gender sensitive counseling at the ART or IPPCC. 2. Understand barriers to access care and treatment services by FSWs and address them.
3	Commodities and Services
3a	Access and Availability of Condoms
	1. Identify condom outlets in the villages from where the FSWs can access condoms. 2. Ensure that condoms are filled and refilled as per need. 3. Directly distribute condoms through peers by assessing the client volume and condom need of each FSW. 4. Demonstrate condom use regularly and organize trainings to make condom use pleasurable 5. Train the sex workers on condom negotiation skills
	Gender Integration
	1. Make female condoms available and accessible. 2. Train the FSWs on condom negotiation skills. 3. Sensitize regular clients/ lovers on responsible behavior and safe sex. 4. Understand barriers to access and use of condoms by FSWs and their clients and address them.

3b	Linkages to STI and Health Services	<ol style="list-style-type: none"> 1. Identify centers accessed by FSWs for medical services and train and prepare the centers to provide STI services 2. Develop referral linkages with Govt. medical centers and with syphilis testing centre.
	Gender Integration	<ol style="list-style-type: none"> 1. Identify and train female doctors for referral. 2. Identify other health needs (ex reproductive and sexual health) of the sex workers and their partners as a couple and provide services for that either directly or through referral. 4. Make available/ accessible counseling services in relation to rape, violence, forced sex etc to the sex worker
4	Enabling Environment	
4a	Sensitizing key influencers	<ol style="list-style-type: none"> 1. Identify of key influencers in the sex work circuit 2. Organize once in a quarter program for lovers and key influencers
	Gender Integration	<ol style="list-style-type: none"> 1. Engage the FSWs in power analysis and identify power structures 2. Focus on sex work and not on the sex worker 3. Empower the FSWs to manage the power structures 4. Provide support to FSWs in case there is backlash from power structures.
4b	Linkages to Rights and Entitlements	<ol style="list-style-type: none"> 1. Identify the need for entitlements (such as housing, ration card, voter ID, etc.) and list beneficiaries. 2. List the beneficiaries. 3. Facilitate linkages with Government schemes. 4. Follow up and ensuring the facilities reach the beneficiaries.
	Gender Integration	<ol style="list-style-type: none"> 1. Give priority to vulnerable sex workers (FSWs with no support, FSWs with young vulnerable daughters)
4c	Linkages for Crisis Response	<ol style="list-style-type: none"> 1. Build FSWs understanding of their rights, entitlements and the law. 2. Develop a crisis management mechanism and train the crisis management team. 3. Provide legal support wherever required. 4. Establish linkages with other organizations and institutions for support.
	Gender Integration	<ol style="list-style-type: none"> 1. Ensure legal support for FSWs to resolve crisis related to family, property, violence, abuse, etc
4d	Advocacy with District Officials	<ol style="list-style-type: none"> 1. Meet the DAPCU officer regularly and send progress reports. 2. Ensure sex workers are included in the DAC as members. 3. Advocate for specific issues of FSWs with the DAPCU or DAC. 4. Follow-up.
	Gender Integration	<ol style="list-style-type: none"> 1. Sensitize the district officials on gender and sex work issues 2. Support the FSWs members of the committee to understand issues of marginalization and denial.
5	Community Mobilization	
5a	Facilitate Critical Thinking	<ol style="list-style-type: none"> 1. Mobilize FSWs to undergo training to build their perspectives on sex work, gender, rights, etc. 2. Facilitate formation of village/site level groups. 3. Facilitate SS/other group activities in these groups and initiate savings if there is a need.
	Gender Integration	<ol style="list-style-type: none"> 1. Focus on providing a critical understanding of sex work, risks, vulnerability and denial. 2. Provide a sense of self-esteem and confidence to get together for collective action.
5b	Facilitate Collective Action	<ol style="list-style-type: none"> 1. Identify activities where collective action is required (for ex. management of events, etc.) 2. Encourage and facilitate FSWs to take collective action. 3. Encourage and facilitate the FSWs to become members of an existing CBO in the district.
	Gender Integration	<ol style="list-style-type: none"> 1. Provide legal support during crisis if needed. 2. Increase FSWs access to productive resources. 3. Increase FSWs control over resources. 4. Acknowledge the potential for violence, abandonment and other negative outcomes that FSWs may face in taking collective action and support interventions to prevent/mitigate such situations. 5. Referral to social services for women who experience negative outcomes.
5c	Facilitate Building an Institution	<ol style="list-style-type: none"> 1. Form site, taluk and district committees with representation of FSWs. 2. Ensure elections to the district committees are conducted periodically. 3. Train/build capacity of management and governance teams. 4. Periodically assess district committees on their growth.

III. Community based care, treatment and support for People Living with HIV and AIDS

Why community based care, treatment and support?

HIV care, treatment and support services are integral to an overall HIV control strategy. They should be interlinked with prevention, social services and advocacy programs for people living with HIV and AIDS (PLHIV). Since more than half of the PLHIV in Karnataka live in rural areas and large majorities of them are not receiving care, treatment and support, it is critical to make these services available to PLHIV living in rural areas. Lack of community based support and referral linkages in rural areas could result in poor access and utilization of ART services. Therefore, it is important to promote care, treatment and support services, in rural areas, in the very villages where PLHIV reside through community based services for the same. Basing services at the community level make them more accessible, and responsive to the needs of PLHIV; encourages participation and create responsibility among members of the local communities.

KHPT promotes comprehensive care services that include preventive (condoms, STI, OI prophylaxis), promotive (nutrition, psychosocial counseling), curative (TB, other OI) and rehabilitative (shelter, educational, vocational rehabilitation) services.

It is important to provide care, treatment and support services for PLHIV in rural areas because large majorities of PLHIV are living in rural areas and have limited access to services that are urban centric. It is important to make these services available at the community level to make them more accessible, and responsive and to create greater responsibility among community members.

Who Are the Target Groups?

PLHIV and their families:

- Men and women who have tested HIV positive.

- Their families, including spouse, children, parents, other members in the family.

Orphan and Vulnerable Children (OVC):

- Children under age 18 (0-17 years) who
- Are HIV positive
- Have HIV positive parent(s) or siblings
- Have lost either or both parents due to HIV

Patients/ Suspects of Tuberculosis (TB)

- Individuals who have symptoms suggestive of TB
- Individuals who have confirmed TB
- Individuals who are on treatment for TB

What Outcomes Are Expected From These Efforts?

- Increased access to and use of HIV and AIDS related non medical services by PLHIV at IPPCC
- Increased early diagnosis and treatment of opportunistic infections among the PLHIV and OVC
- Increased provision of appropriate services to those PLHIV needing livelihood options
- Increase in adherence to ART among PLHIV and CLHIV
- Decreased experience of social isolation, stigma and discrimination by the PLHIV
- Increased participation of PLHIV in support groups or activities of their CBO
- Increased correct and consistent condom use among PLHIV and their partners
- Increased school attendance among OVC
- Increased access to and use of medical and non medical services among OVC
- Increased participation in Life Skills Education sessions among OVC
- Improved nutrition status of the OVC
- Increased participation by general population in care of the OVC
- Increased testing for TB among PLHIV and increased testing for HIV among people infected by TB
- Increased number of TB patients linked with DOTS and completing treatment

What Are the Key Strategies?

- Training and supporting local outreach workers: Community outreach workers and volunteers are trained and supported at the village level to: provide general education about HIV and AIDS; inform rural residents about available services; provide referrals and; follow-up with PLHIV and their families.
- Providing integrated positive prevention and care services: Integrated services for prevention and care are provided through drop-in centers or Integrated Positive Prevention and Care Centers (IPCCC). These centers are managed by PLHIV networks where feasible and partnering NGOs in other places. Rotational outpatient clinics are run through these centers. Services provided include: HIV prevention and treatment counseling; SRH counseling regarding sexuality, safer sex and fertility choices; on-going ART treatment and adherence monitoring; prophylaxis and treatment of OIs; general care and nutritional support; condom distribution; home visits; and referrals for treatment of substance abuse and to CBOs providing home based care.
- Supporting existing care and support centers and networks: Capacities of existing care and support centers run by NGOs, faith based organisations, etc., are strengthened in order to expand the scope and quality of their care and support activities including for family based approach for OVC
- Strengthening and expanding PLHIV networks: PLHIV networks play a leading role in building the capacity of members to practice “positive living” and in assisting PLHIV who have suffered discrimination to seek redress through mediation or referral for legal support. Establishment and strengthening of PLHIV networks builds ownership of PLHIV towards the project and thereby ensures sustainability of its efforts.
- Family approach: To protect vulnerable children and to prevent them from becoming orphaned a whole family approach is adopted. This approach simultaneously addresses the needs of vulnerable parents, especially

mothers, grandmothers and aunts, who are often widowed, uneducated and poor. The whole family approach enables most children to remain in their families and to participate fully in their local communities. Emphasis should be on ‘keeping the mother alive’ by ensuring early access to ART, rather than mere access to hospital care for PPTCT services.

- Progressive care needs approach: PLHIV and their families have diverse and changing needs determined by the progression of the disease and their specific socio-economic profile such as age, gender, availability of supportive family members/ caregivers. A client-centered approach is adopted whereby the various services are oriented to the specific needs of PLHIVs and their families (see box).

Progressive Care Needs	
Risk/Progression of HIV	Care needs
Uninfected but at risk/ vulnerable	Awareness/prevention, STI management, counselling and testing
Asymptomatic HIV	Counselling and Testing
Early HIV disease	Diagnosis and treatment of simple OI
Late HIV disease	OI prevention, Diagnosis and treatment of complicated OI; ART, Treatment counselling
AIDS	Palliative care, ART assessment, adherence counselling; ART monitoring
Terminal stage	Palliative end-of-life care; support for families and communities of PLHIV
Death and bereavement	Psycho-social and economic support for families and communities of PLHIV

What Are the Key Program Components?

1. Psychosocial Care

Support self-disclosure: PLHIV are apprehensive and fearful about disclosing their HIV status to family/ friends and therefore need to understand why disclosure is essential for appropriate

home based care and support. Support them in accepting their positive status and disclosing to family/ friends. In the case of positive children, consult and counsel parents/ caregivers for age-appropriate disclosure.

Support group formation: Encourage PLHIV to form village level/ cluster level groups so that they may support each other. Organize regular reflective/ sharing sessions for them, modifying the SS module as appropriate. For OVC, support formation of children's clubs and facilitate specific activities for them. Encourage children to share experiences with each other. Encourage parents to prepare a memory box for their children (see box on Memory Box).

Provide bereavement counseling: Provide bereavement counseling for family members and children of PLHIV who are terminally ill or dead. Create support structure within family / community to support family members/ children in their bereavement.

Provide treatment counseling: Counsel and refer PLHIV for regular CD4 testing. Those PLHIV who are on ART, should be given adherence counseling, emphasizing on the necessity for continuing treatment. Help the individual to identify a treatment supporter. Follow up with PLHIV who have dropped out of ART or lost to follow-up (LFU). Those who are not on ART should be prepared and counseled on ART and informed about possible side effects. Positive children who are not on ART need to be supported through referrals for pre ART registration and followed up for CD 4 testing. Positive children who are on ART need to be followed up for adherence and pill count every month for at least 6 months and then less intensively. Their parents/ caregivers need to be given counseling on adherence and possible side effects regularly.

Organize life skill education for OVCs: Hold consultations with community and families using the 3 P matrix and develop bridge model/ activity plan. Identify children in the age group of 9-15 years and make groups of 8-15 children each. Complete life skills education sessions for all groups and follow up with these children regularly.

2. Nutrition Support

Assess nutrition status: Assess nutrition status using height, weight and mid-arm circumference measurements and provide supplements and food if required. Assess nutrition status of PLHIV and OVCs. Link children (0-6 years) to the Anganwadi and school (6-14) for supplementary feeding and mid-day meals. Nutrition packets containing powder of cereal-pulse-nut mixes could be produced by the networks and distributed as an additional supplement. Leverage support for food for poor households unable to meet their daily food requirements and ensure that all families have ration cards and receive the subsidized food regularly. Explore feasibility of establishing community kitchens. Encourage development of kitchen gardens and train families in making nutritious food from locally available food items. Assess need for de-worming and provide micro nutrient tablets (Iron Folic Acid, multivitamins) through local clinics.

3. Medical Support

Facilitate OI Management: Conduct clinics and provide OI prophylaxis based on clinical assessment and provide referral for management of difficult OI to CCC or ARTC. Conduct outreach clinics specifically to reach out to women and children. Ensure Co-trimoxazole prophylaxis for all children under 5 years who are exposed and counsel their parents/ caregivers on protocols until the child's HIV status is established. Encourage PLHIV to make regular monthly visits to the clinic and counsel parents of positive children to bring them to the clinics every month.

Make referrals and linkages for TB: TB is the most common opportunistic infection and in some districts in Karnataka, nearly 40 per cent of newly diagnosed TB patients have HIV. Ensure screening for TB symptoms at every clinical visit and follow up diagnosed TB cases with DOTS for complete treatment. Make referrals to DMC (Designated Microscopy Centers) and provide treatment counseling and follow-up.

Support for ART: Those PLHIV who are not on ART need support in referral, registration and follow up for pre ART and for CD 4 testing. Those PLHIV who

are on ART need to be followed up every month with pill count to assess adherence and provided with regular counseling for adherence and on side effects. PLHIV who drop out of ART/ LFU should be put back on ART and counseled on adherence and side effects.

Facilitate STI screening and treatment: Provide information on STI to men and women and provide syndromic case management and follow up. STI among children is rare, however, if children appear with such symptoms, assess history of sexual violence/ abuse and provide referral for care.

Immunization: Ensure that immunization schedule for OVC is followed regularly and counsel the parents/ caregivers about why it is crucial. If HIV/ AIDS related symptoms are observed, refer child for clinical assessment.

Referral to PPTCT: Refer pregnant positive women to PPTCT and counsel the spouse and family for the same. Ensure that they receive the entire package of antenatal care, which includes tetanus toxoid immunization, Iron Folic Acid supplementation and regular check-up every month. Screening for syphilis and checking status for anemia (Hb) and blood group and type is useful for all pregnant women and particularly for those who test HIV positive. Follow up after visit to PPTCT and inform the pregnant woman and her spouse/ family on why institutional delivery is crucial to reduce risk of transmission from positive mother to child and motivate them to do so. Refer the pregnant women for pre-ART registration and CD4 count assessment. If she is eligible for ART, provide ART adherence counseling and support. Counsel the pregnant woman on infant feeding practices and follow up with the mother and child till the child is 18 months old.

4. Positive Prevention

Promote condoms: Counsel on the need for correct and consistent use of condoms with spouse and other sexual partners. Demonstrate correct use of condoms and ensure availability of condoms at clinics, IPPCC and other depots and link PLHIV to these depots. Counsel discordant couples on condom use.

Promote hygiene: Create awareness on personal hygiene, clean water, hygienic food (cooking and eating) practices and sanitation usage.

Encourage spouse and children testing: Use CMIS reports to identify PLHIV whose spouse and children have not been tested. Encourage for spouse and children counseling and testing and make appropriate referrals to ICTCs/ PPTCT. Follow up after test results and enroll those who are found positive into the care program.

Encourage Family Planning: Counsel all eligible couples on family planning methods and make services/ products available at clinics (including condoms, pills, copper T, etc). Counsel and refer couples for other sexual and reproductive health concerns to specialised medical services (for instance for MTP). Provide counseling on sexual health to men, especially youth, using 'Men as Partners' and counsel them on safe sexual practices. Advocate with community members/ parents and caregivers about providing sexual health education to children and impart it through 'life skill education' sessions.

5. Advocacy

Address stigma and discrimination: Develop system and mechanism, such as a crisis response team, at district level, for addressing stigma and discrimination against PLHIV. Inform PLHIV about this system and the services they can access here. Ensure documentation of cases and action taken by crisis response team in Crisis Formats and provide legal and counseling support to those affected. Mobilize support from family, VHSCs, schools, networks/ CBOs and DAPCU for PLHIV facing stigma and discrimination.

Link for legal assistance: Educate PLHIV, their families, communities and workplaces about their legal rights. Establish a system of providing legal assistance to PLHIV and inform PLHIV, families and communities about this system. Provide legal support to PLHIV including for writing of will and guardianship. Ensure there is minimum exposure of OVCs to any form of media so as to protect their confidentiality

Link for social entitlements: PLHIV have needs other than those directly related to their positive status and these could include availability of entitlements (such as Voter ID, ration cards, housing, etc) schooling for their children and so on. These needs must be understood and plans for addressing them must be made in consultation with the PLHIV and by mobilizing local resources/ linking with government/ non-government schemes and programs. Identify needs of PLHIVs, link them with relevant government/ non-government schemes/ programs and follow up to ensure they receive their entitlements.

6. Education/ Vocational Training

Savings and income generation: Identify PLHIV groups who are keen on savings and train them on group savings. Identify PLHIV who are keen to take up income generating activity/ vocational training, assess their preparedness and link them with government or non-government resource agency that would support their activity.

Schooling and vocation training for OVC: Identify out of school/ drop out OVCs in the age group 6-14 years and organise programs to get them back into school. Consult parents/ caregivers to understand obstacles to child's schooling and address them. In case there are financial obstacles, mobilise resources locally to enable children to go to school. Identify appropriate vocational training and resource institutes and link them with children over 14 years of age. Follow up to ensure children under 14 are going to school and those over 14 are receiving vocational training.

7. Protection/ Shelter

Link with care centres: Identify PLHIV and OVC who are in need of shelter and link them with existing shelters such as grandparents, the extended family, foster care, institutional care homes, government run homes and destitute care homes. In the case of OVCs, create awareness about their protection, rights and needs. Identify suitable community based shelters and monitor the quality of care provided. Should community placement not be possible for OVC, place them in government run home and work towards reintegrating them back into the community. In case of child rights

violation, take support form the Child Welfare Committee (CWC) Officer in each district.

Link with Group Insurance Schemes: Link PLHIV groups to group insurance schemes that provide relief to individual and family at the time of severe illness and death.

8. Home and Community Based Care

Identify and mentor caregivers: Discuss the need for caregiver with PLHIV and help them identify appropriate person as caregiver and/or treatment supporter. In the case of OVC use the 'family tree' to identify potential caregivers. Train caregivers on providing home based care, provide HBC kit if required and mentor them through outreach workers. Organise half yearly meetings of caregivers to provide opportunities for sharing experiences. Mobilise volunteers in the community to support home based care.

Form support groups: Form support groups of PLHIV with special focus on women and children. Ensure that these support groups are self-sustaining and encourage positive living and self-sufficiency rather than dependency. Support groups could be made into self-help groups if finance is an issue.

Link with livelihood options: Most PLHIV, especially in women and child headed homes find themselves unable to meet their daily requirements. Many of them are also highly in debt and under the clutches of unscrupulous money lenders. Linking them to saving schemes, small loans, widow pensions, government poverty alleviation schemes and other services ensures that they are able to stand on their feet once more.

Train village level workers: Train the link workers, AWW and care givers at home to recognize early symptoms of severe OI, to refer appropriately those who require treatment and to manage basic and minor ailments at home. Provision of ORS to prevent dehydration during diarrhea, commodities for prevention (condoms) and hygiene (sanitary pads for adolescents and women) and a first aid kit through these workers will help maintain primary health care.

Support for terminal care: Care providers at home must be trained on how to take care of bed-ridden patients or those with incontinence. Provide bereavement counseling to family members and children of PLHIV who die/ are dying. Address issues of stigma or discrimination being faced by the family and mobilise community support system for those experiencing loss. Support writing of a 'will' and its legal recognition. Ensure that last rites are conducted with dignity due to all human beings.

- Give special emphasis to child and women headed families.
- Acknowledge the potential for violence, abandonment and other negative outcomes that women may face in disclosing HIV positive status, and support interventions to prevent/ mitigate such situations.
- Reduce orphan girls vulnerability to sex trade, rape and sexual abuse.
- Understand barriers to access care and treatment by men and women and address

them for example, by making medical care accessible at the PHC level.

- Provide outreach services including follow up through male and female outreach workers.
- Engage men and boys as partners in prevention and in providing care
- Emphasize on partner counseling and testing.
- Provide education on role of gender stereotypes, gender norms, violence, and abuse in the community in HIV/AIDS.
- Address the double stigma surrounding positive MSM and FSWs and assist them access prevention services
- Reduce women's vulnerability to sex work.
- Prioritize widows, deserted women and all OVCs without shelter
- Address inequitable burden of care on women and girls and encourage the paternal extended family to take care of OVCs.

Checklist III. Care for People Living with HIV and AIDS

Program Component		Target Groups	
Target Groups	PLHIV and their families	Orphan and Vulnerable Children Patients/ Suspects of Tuberculosis (TB)	
1	Psycho Social Care		
1a	Support Self Disclosure	1. Counsel on the need for disclosure and support disclosure 2. Support in the acceptance of positive status.	1. Train and counsel parents/ caregivers for age specific disclosure to children.
1b	Support Groups	1. Identify PLHIVs and form Clusters/ Village level Support groups 2. Develop monthly themes and conduct fortnightly/ monthly support group meetings and facilitate sessions as per theme (SS curriculum can be modified). 3. Encourage parents to prepare memory box for their children	1. Create child friendly spaces in IPPC- DIC and conduct regular events for children 2. Provide space to the children to manage these events 3. Form children's clubs to encourage children to express themselves and learn from each other.
1c	Bereavement Counseling	1. Provide bereavement counseling for family members and children of PLHIV who are terminally ill or dead 2. Create support structure within family / community to support family members/ children in their bereavement	1. Provide bereavement counseling for family members and children of PLHIV who are terminally ill or dead 2. Create support structure within family / community to support family members/ children in their bereavement
1d	Treatment/ ART Counseling	PLHIV not on ART 1. Counsel on CD4 testing. 2. Prepare PLHIV for ART 3. Provide current treatment counseling including information on possible side effects, nutrition, hygiene, sexual health, etc.	CLHIV not on ART 1. Referral and follow-up of Pre ART registration. 2. Referral and Follow-up of CD4 count once in 6 months. B. For CLHIV on ART 1. Follow-up once a month/ SOS, especially those in the first 6 months of ART. 2. Conduct pill count to assess ART adherence. 3. Provide counseling for ART adherence to parents/caregivers/ child on each visit 4. Follow-up cases of drop out/ LFU and put them back on ART.
1e	Family Level Counseling	PLHIV on ART 1. Conduct pill count to assess ART adherence. 2. Provide adherence counseling especially to those who have started ART 6 months back. 3. Provide current treatment counseling including information on possible side effects, nutrition, hygiene, sexual health, etc. 4. Follow-up on cases of dropout/ LFU	
		1. Provide counseling to the family on following issues: • Domestic Violence • Domestic Violence • Savings • Marital discord • Sexual health 2. Follow up	
1f	Life Skill Education		1. Hold consultations with community and families using the 3 P matrix and develop bridge model/ activity plan 2. Identify children between 9-15 years of age and form groups of 8 -15 children. 3. Complete LSE sessions and follow up with children's groups.
	Gender Integration	1. Give special emphasis to girls and women headed families. 2. Acknowledge the potential for violence, abandonment and other negative outcomes that women may face in disclosing HIV positive status, and support interventions to prevent/ mitigate such situations. 3 Encourage couple counseling and testing. 4. Refer social services for women who experience negative outcomes. 5. Reduce orphan girls vulnerability to sex trade, rape and sexual abuse.	

2	Nutrition Support	<p>1. Assess nutrition status through measurement, dietary intake, food commonly available/ consumed food, beliefs and taboos around food</p> <p>2. Provide education on low cost and high nutrient food, food and water hygiene and address myths and misconceptions</p> <p>3. Leverage support for nutrition supplements like nutrition mix, ICDS/midday meal, in between snacks etc</p> <p>4. Address food security issues by ensuring that the target family has ration cards, kitchen garden/poultry farm, livelihood programmes if needed, linkage with community feeding programmes</p> <p>5. Manage illness causing poor nutritional status like diarrhea, deworming, dehydration etc</p>	<p>1. Assess the nutrition status and refer to CCC if therapeutic food is needed.</p> <p>1. Assess the nutrition status and distribute Nutrition Packets based on the assessment</p> <p>2. Leverage support for food especially for poor households.</p> <p>3. Encourage development of kitchen garden train family members to make nutritious / palatable meals with locally available food</p> <p>4. Ensure that all families are supplied with government Ration Cards and receive monthly rations.</p>
2c	Micro-nutrient support	1. Assess need for de-worming and provide micro-nutrient tablets through clinics	1. Assess need for de-worming and provide micro-nutrient tablets through clinics
	Gender Integration	1. Pregnant Women, Women or child headed households will be given priority for food	
3	Medical Support		
3a	OI Management	<p>1. Conduct clinics and provide OI prophylaxis based on assessment</p> <p>2. Provide referrals for management of difficult OIs to CCC</p> <p>3. Encourage monthly visits to the clinics, as per NACO guidelines</p>	<p>1. Conduct outreach clinics (especially for women and children if facilities are available)</p> <p>2. Ensure Co-trimoxazole prophylaxis for all children under 5 years who are exposed.</p> <p>3. Provide referrals for management of difficult OIs to CCC.</p>
3b	TB - Referrals and Linkages	<p>1. Ensure screening for TB symptoms and follow up diagnosed TB cases for DOTS</p> <p>2. Make/ provide referral to DMCs.</p> <p>3. Provide treatment counseling and follow up</p> <p>4. Provide linkage to OI prophylaxis</p> <p>5. Provide linkage to ART if HIV positive</p>	<p>1. Ensure screening for TB symptoms and follow up diagnosed TB cases for DOTS</p> <p>2. Make referral to DMCs.</p> <p>3. Provide treatment counseling</p> <p>4. Identify care giver</p>
3c	ART Support	PLHIV not on ART	CLHIV not on ART
		<p>1. Provide referral and follow-up for Pre ART registration.</p> <p>2. Provide referral and follow-up for CD4 count once in 6 months.</p>	<p>1. Provide referral and follow-up for Pre ART registration</p> <p>2. Provide referral and follow-up f CD 4 count once in 6 months.</p>
		<p>1. Follow-up once a month/ SOS, especially those who are in the first 6 months of ART.</p> <p>2. Conduct pill count to assess ART adherence and provide ART adherence counseling on each visit.</p> <p>3. Follow-up of cases of drop out/ LFU and put them back on ART.</p> <p>4. Provide counseling on side effects.</p>	<p>1. Follow-up once a month/ SOS, especially those who are in the first 6 months of ART.</p> <p>2. Conduct pill count to assess ART adherence.</p> <p>3. Provide ART adherence counseling to parents/caregivers/ child on each visit.</p> <p>4. Follow-up cases of drop out/ LFU and put them back on ART.</p> <p>5. Provide counseling on side effects to parents/ caregivers</p>
3d	STI Screening and Treatment	<p>1. Provision of information about STI to men and women.</p> <p>2. Provide syndromic case management and follow up.</p>	<p>√ STI among children is rare. If children appear with such symptoms, assess history of sexual violence/ abuse.</p>
3e	Immunization		<p>1. Ensure immunization schedule is followed.</p> <p>2. Provide counseling to parents.</p> <p>3. If HIV/AIDS related symptoms are observed, refer child for clinical assessment.</p>
3f	Referral to PPTCT	<p>1. Refer pregnant women to PPTCT and counsel the spouse and family</p> <p>2. Follow-up, give information on need for institutional delivery and motivate the couple to do so.</p> <p>3. Counsel on infant feeding practices</p> <p>4. Follow-up both mother and child till 18 months.</p>	
	Gender Integration	<p>1. Understand barriers to access care and treatment by men and women and address them for example, by making medical care accessible at the PHC level. 2. Make these medical services available at the TI clinics to ensure MARPS have access to care related medical services. 3. Identify and train, male and female doctors to provide medical services 4. Provide outreach services including follow up through male and female outreach workers.</p>	

4	Positive Prevention		
4a	Disclosure of status	<ol style="list-style-type: none"> 1. Encourage acceptance of HIV positive status and counsel on the need for disclosure. 2. Provide peer testimonial counseling 3. Support disclosure to spouse or family 4. Encourage positive speakers. 	<ol style="list-style-type: none"> 1. Train and counsel parents/ caregivers for age specific disclosure to children.
4b	Condom Promotion	<ol style="list-style-type: none"> 1. Counsel on the need for correct and consistent use of condom with spouse and other sexual partners. 2. Demonstrate correct use of condoms. 3. Ensure availability of condoms at the clinics, IPPCC and other depots and link individuals to depots 4. Counsel all couples on condom use 	
4d	Hygiene and Sanitation	<ol style="list-style-type: none"> 1. Create awareness on personal hygiene, clean water, hygienic food cooking and eating practices and sanitation usage. 	<ol style="list-style-type: none"> 1. Create awareness on personal hygiene, clean water, hygienic food practices and sanitation usage.
4e	Spouse and children testing	<ol style="list-style-type: none"> 1. List PLHIVs whose partners have not been tested, using CMIS reports. 2. Encourage/counsel PLHIV to get their spouse and children tested. 3. Make referrals to ICTCs/ PPTCT, follow up and enroll in care program. 	
4f	Family Planning /Sexual and Reproductive Health	<ol style="list-style-type: none"> 1. Counsel all eligible couples on various family planning methods available. 2. Provide FP services (condoms, pills, copper T) in the clinics 3. Refer couples to other medical services for other FP services like such as, MTP, etc. 4. Provide sexual health education to men, especially youth, through special sessions using the tool 'Men as Partners' 5. Provide counseling services to youth on safe sexual practices 	<ol style="list-style-type: none"> 1. Advocate with parents/community/caregiver on the need for children to learn about sexual health 2. Provide sexual health education to children through Life Skill Education sessions
	Gender Integration	<ol style="list-style-type: none"> 1. Engage men and boys as partners in prevention 2. Ensure vulnerable men and women have access to prevention services. 3. Involve both partners in taking decision on FP method. 4. Emphasize on partner treatment. 5. Provide education on role of gender stereotypes, gender norms, violence, and abuse in the community in HIV/AIDS. 6. Address the double stigma surrounding positive MSM and FSWs and assist them access prevention services 7. Provide support to women and MARPS to manage the negative effects of disclosure, if any 8. Encourage couple counseling and testing. 	
5	Advocacy		
5a	Stigma and Discrimination	<ol style="list-style-type: none"> 1. Develop a system in the district to address stigma and discrimination/ crisis issues (similar to a crisis management system). 2. Inform PLHIV (through clinics, support groups, outreach, etc.) about this system and the services it provides. 3. Support PLHIVs facing S&D issues and provide counseling wherever needed 4. Facilitate support to PLHIV from family, VHSCs, schools, networks/ CBOs, DAPCU 5. Document cases of discrimination and action taken in Crisis Formats. 	<ol style="list-style-type: none"> 1. Develop a system in the district to address stigma and discrimination/ crisis issues (similar to a crisis management system). 2. Inform PLHIV (through clinics, support groups, outreach, etc.) about this system and the services it provides. 3. Support PLHIVs facing stigma and discrimination issues and provide counseling wherever needed 4. Facilitate support to PLHIV from family, VHSCs, schools, networks/ CBOs, DAPCU 5. Document cases of discrimination and action taken in Crisis Formats.
5b	Linkage for Legal Assistance	<ol style="list-style-type: none"> 1. Educate PLHIV, families, communities and workplaces on legal rights of PLHIVs. 2. Establish a system to provide legal support and inform PLHIV, families and communities about this system 3. Provide legal support including writing of will and guardianship. 	<ol style="list-style-type: none"> 1. Educate PLHIV, families, communities and workplaces on legal rights of PLHIVs. 2. Establish a system to provide legal support and inform PLHIV, families and communities about this system 3. Provide legal support including writing of will and guardianship. 4. Ensure there is minimum exposure of OVCs to any form of media (print and visual) so as to protect their confidentiality.
5c	Social Entitlements	<ol style="list-style-type: none"> 1. Identify the need and list beneficiaries. 2. Facilitate linkage with government schemes and follow up to ensure the facilities reach the beneficiaries 	<ol style="list-style-type: none"> 1. Identify the need and list beneficiaries. 2. Facilitate linkage with government schemes and follow up to ensure the facilities reach the beneficiaries

6	Education/ Vocational Training		
6a	Linkages	<ol style="list-style-type: none"> 1. Identify groups who want to take up vocational training and income generation activities 2. Start a process of savings in the groups and train them to manage savings 3. Assess preparedness of the group to start IGP. 4. Identify resource agencies to support IGP and link up with government and non-government schemes. 	<ol style="list-style-type: none"> 1. Identify OVC who are school dropouts and admit under 14 to schools. 2. Assess the situation of the child at home and counsel the guardians/ parents and school about readmitting/ admitting children to school. 3. Provide financial support for schooling by generating community and local school support. If not, then organize support from IPPCC for costs of uniform/ books, etc. 4. Identify vocational training centers in the region and link children above 14 with them. 5. Follow up on children admitted to schools and enrolled in training centers.
	Gender Integration	1. Prioritize women headed and girl child-headed households. 2. Increase women's access to productive resources 3. Increase women's control over resources 4. Reduce women's vulnerability to sex work.	
7	Protection/ Shelter		
7a	Linkage to Foster Care, Short Stay homes and Destitute care home	<ol style="list-style-type: none"> 1. Identify various foster care homes, government short stay homes/ schemes 2. List the beneficiaries based on the need, link with above and follow up. 	<ol style="list-style-type: none"> 1. Raise awareness in the community about child protection 2. Find suitable and safe shelter within the community for the OVC and follow up to assess the quality of care. 3. Place OVC in identified government shelter if community placement is not immediately possible and continue to work towards reintegration into the community. 4. Take help of child support centers in case of rights violation
	Gender Integration	Prioritize widows, deserted women and all OVCs without shelter	
8	Home Based Care (Ambulatory and Bedridden)		
8a	Identification of Care Giver	1. Discuss the need for caregiver with PLHIV and support them in identifying the right person as caregiver. 2. Identify supportive volunteers in the community.	<ol style="list-style-type: none"> 1. Use family tree to identify potential caregivers for OVCs. 2. Identifying supportive volunteers in the community
8b	Mentoring/ Counseling of the Care Giver	<ol style="list-style-type: none"> 1. Train the caregivers and volunteers on providing home based care. 2. Provide on-the-job mentoring to the caregivers through outreach workers 3. Organize half yearly meetings for caregivers for sharing experiences. 	<ol style="list-style-type: none"> 1. Train the caregivers and volunteers on providing home based care. 2. Provide on-the-job mentoring to the caregivers through outreach workers 3. Organize half yearly meetings for caregivers for sharing experiences.
8c	Provision of Home Based Care Kits	1. Identify households that need HBC kit, provide kit to caregiver and train them on use of HBC	1. Identify the OVC households that need HBC kit
8d	Terminal Care	<ol style="list-style-type: none"> 1. Provide bereavement counseling to family members and children and provide support for funeral. 2. Extend support of Rs. 1000/ per family based on the need, to a maximum of 10 families per year. 3. Address issues of stigma and discrimination if faced by the family. 4. Develop community support system for those experiencing loss. 	<ol style="list-style-type: none"> 1. Provide bereavement counseling to family members and children and provide support for funeral. 2. Extend support of Rs. 1000/ per family based on the need, to a maximum of 10 families per year. 3. Address issues of stigma and discrimination if faced by the family. 4. Develop community support system for those experiencing loss.
	Gender Integration	1. Engage men and boys in providing care 2. Encourage the paternal extended family to take care of OVCs. 3. Address inequitable burden of care on women and girls.	

Be gender sensitive and inclusive:

- Women's lack of power over economic means they have less control over sexual decision-making, which is critical to protection against STIs and HIV infection. Also, the HIV epidemic carries disproportionate opportunity costs for women as a result of their traditional roles of caregivers and nurturers of the ill and dying
- Foster women's agency so that women can demand and use health services and practice healthy behaviors.
- Work strategically with men to reduce gender violence, to increase access for themselves and their partners to VCT, PMTCT and HIV/STI services
- Address sex work, and not just with sex workers, including a focus on both sex workers and sex clients
- Address the economy of sex work, and where feasible, promoted income-generation alternatives for women who want to leave sex work
- Large number of PLHIV, especially women, are not receiving ART largely due to the lack of community based support and lack of referral linkages
- Enable vulnerable children to remain with their families- address needs of vulnerable parents, especially mothers, grandmothers and aunts who are often widowed, uneducated and poor.
- Support home-based care services to recruit more men as volunteer caregivers, motivate men to assume greater role as care giver.
- Integrate gender into training topics across the board, including conducting situation needs assessments, community mobilization, HIV voluntary counseling and testing, and STI treatment



Karnataka Health Promotion Trust



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