



**USAID**  
FROM THE AMERICAN PEOPLE



**PEPFAR**  
U.S. President's Emergency Plan for AIDS Relief

**AIDSTAR-One | CASE STUDY SERIES**

**August 2012**

# District Comprehensive Approach for HIV Prevention and Continuum of Care in Maharashtra, India



Sarathi, Nagpur

Prevention campaign in Nagpur.

**T**he attempt to control the HIV epidemic is on exhibit in the city streets of the Aurangabad and Nagpur districts of Maharashtra. Looped red ribbons, symbols of this effort, adorn the walls and lamp posts, publicly expressing the district administration's commitment to the prevention and control of HIV. Billboards, signposts, and prominent display ads on public transport vehicles are designed to boost public awareness of the virus. But are government commitment and public outreach enough to make a positive impact on public and individual perceptions of HIV, when social stigma and fear turn the detection of vulnerability into a Herculean task?

In these two districts, where HIV prevalence among specific most-at-risk populations is very high, the Avert Project in collaboration with the Government of Maharashtra, funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Agency for International Development, has launched a broad-based and participatory strategy for HIV prevention and management. This strategy, the District Comprehensive Approach (DCA), links available public, private, and community resources to identify and reach those who are most vulnerable to HIV with comprehensive services.

The implementation of DCA in Aurangabad and Nagpur has led to increased access to and use of HIV services by target groups, and has also enhanced community understanding of HIV and reduced stigma. This positive result, based on 1) a coordinated approach to synchronize services with needs and 2) a flexible networking process that supports outreach by diverse groups, sets the stage for expansion to other

**By Molly Charles**

**AIDSTAR-One**

John Snow, Inc.  
1616 North Ft. Myer Drive, 16th Floor  
Arlington, VA 22209 USA  
Tel.: +1 703-528-7474  
Fax: +1 703-528-7480  
www.aidstar-one.com

This publication was made possible through the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development under contract number GHH-I-00-07-00059-00, AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

districts of Maharashtra and suggests implications for HIV strategies at the national level.

This case study looks at the inroads made by the DCA in creating an enabling environment for HIV management in Aurangabad and Nagpur. It focuses on the process by which the DCA was created, the main operating mechanisms of the approach, its outcomes to date, and its potential role in HIV management at the state level. The report covers the two-year period (2009–2011) during which the Avert Society launched the DCA and functioned as the principal coordinator of DCA activities.

Information for this case study is based on field observations, review of documents and quantitative data provided by the Avert Society, and interviews and guided interactions with professionals from the Avert Society, the District AIDS Prevention and Control Unit, integrated counseling and testing centers (ICTCs), and antiretroviral treatment (ART) centers. Other stakeholders who provided input included individuals working with networks of people living with HIV (PLHIV), targeted interventions, and the Link Workers Scheme, as well as private practitioners, members of high-risk and vulnerable groups, and community leaders working at the village and district levels.

This case study is limited due to the DCA being operational for a period of two years prior to documentation, and because the study is based on an explorative, short-term, one-time field assessment.

## Decentralization and HIV Management in India

The number of PLHIV in India is estimated at 2.39 million (The National AIDS Control Organisation [NACO] 2011a). NACO, established in 1992, is the Indian government agency charged with addressing the country's HIV epidemic along with the National Council for AIDS.

As understanding of the epidemic increased, NACO's strategies were adapted to address regional differences within their sociocultural context. The strategies that evolved included the development of a conceptual framework that covered program planning and implementation, monitoring and documentation, and epidemiological surveillance through the National AIDS Control Programme (NACP), which is now in its third phase.

NACO initially concentrated on reducing HIV incidence through centralized activities such as information, education, and communication campaigns to draw public attention to the issue, along with the establishment of a surveillance system to ensure safer blood supply. Later, NACO sought to decentralize programs to address regional differences, by handing over program implementation to state AIDS control societies.

NACO's decentralization efforts began with the NACP Phase II (2001–2005), which was a move toward participatory, comprehensive, and locally relevant programming, and was further expanded under the NACP Phase III (2006–2011; NACO 2006). The government, on its part, strengthened the role of local bodies of governance and nongovernment agencies through the medium of micro-level planning to facilitate joint implementation of programs by local and government agencies. These efforts to combat HIV at the local level built on experience gained while employing micro-level planning in other areas, such as education and sanitation (United Nations Children's Fund 2003).

For the NACP Phase IV (beginning in mid-2012), NACO emphasizes further decentralization at the district and sub-district levels and greater focus on high-risk, marginal, and hard-to-reach groups (NACO 2011b). This strategy responds to NACO surveillance data that show widely varying levels of incidence and vulnerability—classified "A" through "D" in descending order of severity—at the district level. To address HIV in high-incidence districts

(including those in Maharashtra), the government created District AIDS Prevention and Control Units that coordinate HIV control and prevention strategies in “A” and “B” districts. Each District AIDS Prevention and Control Unit develops a comprehensive plan to synchronize and mainstream HIV-related activities within the existing public health care infrastructure and programs at the district and sub-district levels.

The intention behind the DCA pilot was to establish a network linking public, private, and community-based HIV services that District AIDS Prevention and Control Units could take over and manage once the pilot period ended.

## HIV and the District Comprehensive Approach in Maharashtra

Maharashtra is among India’s high-prevalence states, with around half a million PLHIV and an adult HIV prevalence of 0.55 percent, compared to 0.31 percent overall in India in 2009 (see Table 1). Of its 35 districts, 32 fall under category A, with over one percent prevalence in antenatal care/prevention of parent-to-child transmission services (NACO 2006). In 1998, the state government established the Maharashtra State AIDS Control

	India	Maharashtra
PLHIV	2,395,442	419,789
Children living with HIV	104,450	23,831
PLHIV on ART	380,314	90,484
PLHIV registered	1,253,498	261,442
Children on ART	23,854	6,301
AIDS-related deaths	172,041	36,771
New infections	120,668	11,287

Source: NACO 2011A.

Society and Mumbai District AIDS Control Society to manage efforts to control and prevent HIV.

### **The local context—multiple risks:**

Residents of the Nagpur and Aurangabad districts are vulnerable to communicable diseases, including HIV, because of development dynamics and demographics. Both districts are industrialized, with a well-developed transportation infrastructure, and are also favorite tourist spots. The consequent “floating” population exposes the local communities to several risk factors related to alcohol use and unsafe sexual activity. Women face multiple challenges, including gender-based discrimination, illiteracy, and restricted social mobility, which limit their ability to benefit from intervention programs. Female sex workers (FSW) and men who have sex with men (MSM) face marginalization for their sexual behavior or orientation and the discrimination is far greater towards FSWs and MSM who are economically and socially vulnerable.

### **Launching the District Comprehensive Approach:**

The DCA began in 2009 as a pilot initiative in both rural and urban areas of Nagpur and Aurangabad with the intention of subsequent expansion to other districts in Maharashtra. The project built on previous experience with micro-level planning as well as evidence from several African countries showing that a comprehensive, integrated approach, such as that of the DCA, can play a critical role in improving access to services and reducing stigma (Fullem 2003; Gulu District Local Government 2008).

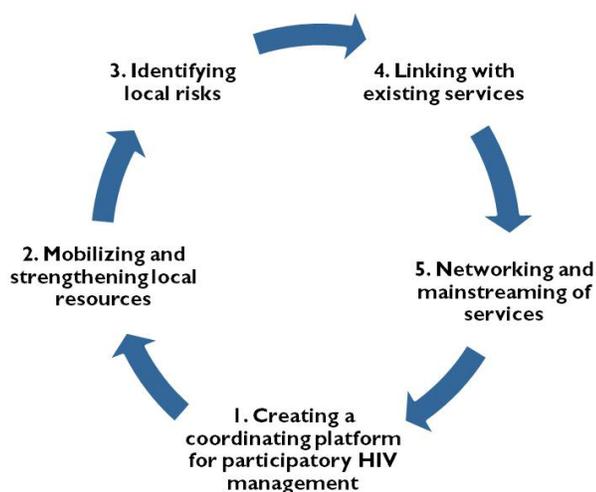
The Avert Society<sup>1</sup> initially coordinated the activities in collaboration with various partner organizations including the Maharashtra State AIDS Control

<sup>1</sup> The Avert Society was a 10-year project established in 2001 as part of a bilateral partnership between the Government of India and the U.S. Agency for International Development to complement the efforts of the Government of Maharashtra in addressing the HIV epidemic in the state. The Avert Society worked with state, community, and nongovernmental organizations, including PLHIV, to improve the availability and access to care for vulnerable groups in both rural and urban areas.

Society, the District AIDS Prevention and Control Units in Nagpur and Aurangabad, local and international intervention agencies in the two districts, and several networks for PLHIV.

A fundamental tenet of the DCA is that all projects and initiatives collaboratively focus on the local context and conditions. The approach emphasizes quality care that respects individual rights and provides access to timely and caring services. Figure 1 shows the steps that the Avert Society took to set up the DCA for HIV; discussion of the steps follows.

**Figure 1. District Comprehensive Approach and HIV**



## 1. Creating a coordinating platform for participatory HIV management

The Avert Society began by holding a district-level coordination meeting that brought together all the agencies working in the field of HIV to discuss the need for HIV management for the district as a whole, rather than through isolated programs. Developing a district-wide system required consensus from all partners involved. An important first step was the joint preparation of a “status note” describing the resources available for HIV management in the district and identifying gaps in

HIV services. This process gave a broad picture of the available human, community, institutional, and infrastructure resources that could play a role in HIV management.

## 2. Mobilizing and strengthening local resources

Based on information from the status note and data on HIV infection and comorbidities, the Avert Society and participating stakeholders identified gaps in public and private services and set out to strengthen existing programs for vulnerable groups through ongoing capacity building and service upgrades. The measures taken matched the local context. For example, to address the relationship between alcohol use and inconsistent condom use, the Avert Society developed peer-based preventive measures that target individual concerns. The DCA also used link workers (outreach workers who are from the rural community that they work in) to mobilize and enhance local resources, especially in rural areas (see Box 1).

## 3. Identifying local risks

Central to the success of the DCA is its ability to identify and address local vulnerability to HIV among individuals and groups, including PLHIV and those who are affected by HIV, such as families. Vulnerability implies susceptibility not only to HIV infection, but also to co-morbidities, effects on the family, mental health concerns, and stigma.

In urban areas, nongovernmental organizations and networks for PLHIV play a significant role to address concerns of high-risk groups; in rural communities, the Link Workers Scheme is central.

## 4. Linking with existing services

The practical implementation of DCA required that diverse service provider agencies be linked to ensure access to various types of services, including those provided by ICTCs, drop-in centers, community care centers, and centers for

prevention of parent-to-child transmission. This entailed dividing the district into smaller areas based on coverage by different agencies, and creating informal systems for information sharing to facilitate timely intervention and prevent duplication of services. The district agencies mainly focused on HIV prevention and community care, whereas the Avert Society and other agencies handled capacity building and communication.

### 5. Networking and mainstreaming of services

The DCA laid the grounds for improved networking and helped to mainstream services for HIV management. This networking brought together not only agencies like the Department of Health, which is directly concerned with HIV management, but also other agencies such as those dealing with welfare, social justice, and education.

Data input from various actors in the DCA network provided information on multiple aspects of HIV

management; the availability of these richer data greatly enhanced district-level programs for prevention and care. A system was developed for collection, collation, and dissemination of information to various agencies to provide a continuous stream of information on HIV services and gaps in capacity building and infrastructure development. The system also allows for the transfer of both raw data and synthesized information from the district level to the state and national levels, which in turn provides evidence to shape state and national policy.

**The Avert Society's initiatives to manage HIV:** To address high prevalence within the districts, the Avert Society focused DCA efforts on identifying, contacting, and providing services to the most vulnerable and at-risk groups. In these districts, the target groups were FSWs, MSM, and migrants (and, in Nagpur, also truckers). Initiatives included:

### BOX 1. LINK WORKERS AND THE DISTRICT COMPREHENSIVE APPROACH

The Link Workers Scheme is a community-based project launched under NACP Phase III as a way of increasing the availability of HIV prevention, testing, treatment, and support services for high-risk groups based in rural areas where, according to surveillance, over half of India's PLHIV live. In these settings, link workers, who know and have close ties to the community, are well placed to discuss sensitive information and intervene in an appropriate manner. In Aurangabad and Nagpur, the Avert Society supported the launch of the Link Workers Scheme.

Trained village-based link workers, ideally one man and one woman per village, use local mapping to identify and establish contact with PLHIV and those at risk, promote condoms among these groups, help PLHIV connect with available services, and liaise with families and the community to help decrease stigma (NACO 2009). Within the DCA, link workers were central to improving access to and use of HIV services. They carried out a wide range of activities, including:

- Sensitizing families and communities to the needs of PLHIV
- Linking PLHIV to the appropriate services for testing, treatment, care, and support
- Selecting youth from each community to serve as peer educators
- Training 1,000 young people in local mapping and surveying
- Providing youth and women the skills to plan for preventive intervention
- Setting up village information centers, or *Saiyukta*, which provide diverse services to PLHIV and their families.

- Developing community-based and peer-led initiatives to cover high-risk groups, and providing services to them in towns and cities to the point of saturation. In semi-urban and peripheral areas, nongovernmental and community-based organizations played an active role in service provision.
- Providing mobile testing services in select locations for high-risk groups.
- Setting up the Link Workers Scheme for HIV management at the village level, reaching 100 villages per district.
- Mainstreaming HIV management in all government departments to link PLHIV and their children with various government welfare schemes.
- Setting up community care centers, supported by the Karnataka Health Promotion Trust with funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria, to facilitate care for PLHIV, treatment for adverse reactions to ART medication, and support for psychosocial needs.
- Setting up a drop-in center focusing on concerns of PLHIV within the dynamics of family and community.

The DCA also made use of other services: ART centers in each district along with link ART centers (rural ART care centers that are linked to major ART centers: five in Nagpur and four in Aurangabad); 21 ICTCs; 29 primary health centers with round-the-clock service; private/public partnership ICTCs (14 in Nagpur and 2 in Aurangabad); and community care centers.

## The Program Areas

The DCA estimated the population of high-risk groups to be reached (see Table 2). The Avert

Society used several different measures to address the unique needs of its priority populations based on the specific characteristics of the high-risk groups in each locality.

**Female sex workers:** In Nagpur, the Avert Society targeted brothel-based and non-brothel-based sex workers. In Nagpur, brothel-based FSWs are often illiterate single women who have come from other states<sup>2</sup> or from distant places within Maharashtra. The women enter the profession to add to their family income and subsequently find few other options open. In Aurangabad, the DCA targeted FSWs, who are generally non-brothel based, married, and over the age of 30, and see sex work as an additional source of family income. These women stress anonymity to safeguard their family life. However, this arrangement may interfere with safe sex practice; because of power imbalances and the fear of detection it may be difficult for a wife to keep condoms close at hand and to insist that her husband use condoms.

Increasing awareness about communicable diseases, especially sexually transmitted infections (STIs), is crucial to reduce vulnerability to HIV. Nearly half (45 percent) of FSWs are unaware of signs and symptoms associated with STIs, and even those who are aware of STIs have limited knowledge. Principles of behavior modification call for attitudinal change along with improved knowledge. Despite awareness about HIV and testing services, the utilization of ICTC services was initially low at 28 percent (Avert Society 2008). To change the situation, the Avert Society created an enabling environment by mobilizing outreach workers, counselors, and link workers within the public health care system, while also building awareness and focusing on attitudinal change to ensure informed decision-making by FSWs. In 2010, the situation changed and utilization of ICTC

<sup>2</sup> Field data from key informants indicated there are a lot of women who have come from Northern States to make a living from brothel-based work.

services increased to 49 percent among referrals made for 3,440 FSWs in Aurangabad.

**Men who have sex with men:** MSM are socially marginalized and discriminated against both in Nagpur and Aurangabad. Many live double lives—one as part of the MSM community, and another as part of a family that is unaware of their sexual orientation. This is a mobile population; around 70 percent of MSM interviewed travel on a regular basis. Furthermore, a significant proportion of MSM surveyed under the Behavioral Surveillance Survey reported their first sexual experience was forced (Avert Society 2010a; 2010b). This suggests concerns with regard to human rights violation and safe sex for this population. Mobilizing MSM themselves as human resources is difficult because of their fear of being stigmatized if they reveal their sexual orientation, though they are willing to offer support from behind the scenes.

To address the concerns of this population, the DCA focused on increasing awareness of the challenges that MSM face—for example, insensitivity within the health care system—and helped orient professionals and lay persons to the needs and dynamics of groups with nontraditional sexual orientations. Peer-based interventions played a central role, especially in reaching hidden

members of the MSM community. The peer-based initiative focused on addressing risk perception and the use of condoms. Peers can help MSM have safer sex by providing a rational assessment of risks, as well as information on tests and testing facilities for STIs and HIV.

**Migrants:** The migrant population comprises mostly contractual laborers who offer their services to established enterprises and loosely formed contractual ventures in the district. Most migrants come from other states and many work in hard labor because there are not many local takers.

Many situational factors make migrants vulnerable to HIV infection. Isolation may drive some men into temporary MSM relationships or sex with a FSW. Migrants often work in underdeveloped areas lacking even basic amenities, and personal hygiene and sanitation are issues of concern, especially in drought-prone areas. The harsh work pattern of migrants, which allows minimum leisure time, requires that all intervention activities for this group adopt a holistic approach that recognizes their needs and limitations. In Aurangabad and Nagpur, DCA developed mobile health care services based on the understanding that migrants would not want to lose their daily income by traveling long distances to seek HIV testing and other health services.

	<b>Aurangabad target population</b>	<b>Aurangabad population reached with services</b>	<b>Nagpur target population</b>	<b>Nagpur population reached with services</b>
<b>FSWs</b>	3,735	3,440	7,057	5,415
<b>MSM†</b>	425	951	670	1,353
<b>Migrants</b>	37,842	24,733	80,025	66,166
<b>Truckers (Nagpur only)‡</b>			40,000	

\* Data for population reached with services is for the period 2010–2011, provided by the Avert Society.

† Estimation for the population of MSM in both Nagpur and Aurangabad is low as MSM were initially reluctant to disclose their sexual orientation. Over time and through the participatory mapping exercise, good rapport was increased, facilitating identification and interaction with a larger number of the MSM population.

‡ This total represents the number of truckers targeted by several initiatives; Avert’s target was 10,000.

## A Brief Overview of Changes Achieved

The DCA set ambitious targets for reaching key high-risk groups in Aurangabad and Nagpur. Because the initiative began only in 2009 and took some time to achieve full implementation, it is difficult to track its full impact. However, Avert Society staff reported that they had seen significant improvements in coverage and service use beginning in the second year (2010–2011). Highlights of major impacts are included here.

### **Covering vulnerable populations:** NACP

Phase III focused on the need for targeted interventions to identify hidden members within high-risk groups, bridge populations such as migrants, and women exposed to HIV through the risk-taking behavior of their partners. The DCA facilitated access to rural populations that are often inadequately covered through district-level programming, largely through the Link Workers Scheme. To ensure continuity of coverage, link workers formed 108 Red Ribbon Centers (HIV prevention centers) in Nagpur and 100 in Aurangabad, and identified over 1,000 young people in each district for training as peer educators. To ensure quality of care in the implementation of the DCA, the Avert Society focused on increasing the availability and accessibility of services—for example, by extending hours and providing mobile testing units—and on creating a supportive environment within health care institutions or units.

**Utilization of clinical services and HIV testing:** Utilization of all clinical services, including those for HIV, increased under the DCA. In Aurangabad, the number of FSWs seeking services increased from 5,785 in 2010 to 11,591 by April 2011. Service utilization among MSM increased over fivefold from 314 in 2010 to 1,529, and increased fourfold (to 8,051) for migrants.

The number of individuals from all high-risk groups in Nagpur (FSWs, MSM, migrants, and truckers) who received HIV tests increased from 221 (in 2007, before the implementation of the DCA) to 17,879 in 2010. Disaggregation of these overall figures shows a clear increase in utilization of ICTC services across subgroups—among FSWs, for example, use of ICTCs increased from 235 in 2009 to 4,512 in 2010.

As indicated previously, link workers were central to increased use of services in nonurban areas. Table 3 shows referrals to and use of HIV testing services by specific groups in rural areas of Nagpur.<sup>3</sup>

Importantly, the utilization of services for STIs also increased among vulnerable and high-risk groups, as shown in Table 4.

Data for Nagpur on the utilization of testing services for prevention of parent-to-child transmission among women who received counseling shows an increase from 81.3 percent to 91.33 percent in 2010.

**Other supportive services:** The DCA facilitated care of PLHIV by making diverse services available and accessible through drop-in centers, community care centers, and ART centers. Services provided include identification of new HIV infections, counseling for PLHIV, facilitating access to and utilization of ART care and treatment for co-morbidities, and strengthening home-based care along with social support structures within the community. Prior to 2009 in Aurangabad, no individuals from high-risk groups had been linked to ART care when they tested positive, but during 2010 to 2011, 36 FSWs, 7 MSM, and 6 migrants were receiving ART.

In Nagpur, support services were provided through drop-in centers. During the first two years of the DCA, 1,631 PLHIV, including 143 children, received

<sup>3</sup> Breakdowns of data by rural versus urban origin were only available in Nagpur.

**TABLE 3. ICTC SERVICES PROVIDED TO HIGH-RISK GROUPS BY LINK WORKERS IN NAGPUR**

	ICTC Referrals				ICTC Tested			
	Migrant	Vulnerable groups	Truckers	High-risk groups	Migrant	Vulnerable groups	Truckers	High-risk groups
<b>2010</b>	25,553	270	3,012	1,949	7,760	120	1,450	463
<b>2011</b>	31,046	5,307	5,489	2,651	9,537	1,394	1,452	1,277

**TABLE 4. STI SERVICES PROVIDED TO HIGH-RISK GROUPS BY LINK WORKERS IN NAGPUR**

	STI Referrals				STI Tested			
	Migrant	Vulnerable groups	Truckers	High-risk groups	Migrant	Vulnerable groups	Truckers	High-risk groups
<b>2010</b>	1,933	120	1,052	1,052	846	65	542	791
<b>2011</b>	4,264	1,270	985	2,172	2,349	299	456	1,195

care at the drop-in center, almost a threefold increase over the 673 PLHIV who received care during 2006 to 2009.

Promotional camps implemented by drop-in centers helped PLHIV gain access to relevant government schemes, such as food support, for which they might be eligible. Camps held between April and June 2010 resulted in 1,274 referrals, and of these, 407, or 31 percent, received benefits. Referrals to non-HIV services made outside the camp setting between 2006 and March 2011 totaled 700, with 6 percent receiving benefits.<sup>4</sup>

Other services provided through different agencies in Nagpur and Aurangabad under the DCA included:

- Home visits focusing on strengthening ART adherence and also addressing concerns with health, hygiene, nutrition, legal issues, and cases of discrimination. Both adults and children received social support and ART care as part of the CHAHA<sup>5</sup> project. Table 5 shows the services

provided through drop-in centers and home visits in Nagpur.

- Self-help groups: under the DCA, the number of self-help groups increased relative to previous years. For example, 61 such groups were formed in Aurangabad. One group, comprised of a mixed membership that included FSWs, developed an innovative mobile service to care for unclaimed dead bodies in the city, including organizing last rites.
- Positive prevention among discordant couples to reduce additional infection.
- Financial schemes: links were established with private microfinance companies, Panchayat Samathi and Municipal Corporation, to build the capacity of self-help groups to market their services or products and strengthen their micro-ventures. An insurance scheme for FSWs, Janashree Insurance Policy, was also initiated.

The DCA sought to address gaps in service and ensure optimal utilization of all existing services as a means to reduce HIV prevalence in its target areas. Surveillance data show that the incidence of HIV among ICTC clients reduced from 11.7 percent to 4.7 percent between 2007 and 2010. Many factors could contribute to this reduction, including

<sup>4</sup> The drop-in center camps were held only in Nagpur.

<sup>5</sup> CHAHA (wish) is a program initiated by the India HIV/AIDS Alliance with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. It focuses on mitigating the adverse impacts of HIV on children through a holistic response to meet the needs of children affected by HIV and their families.

**TABLE 5. SUPPORT SERVICES PROVIDED THROUGH DROP-IN CENTERS/HOME VISITS IN NAGPUR**

	ART adherence and nutrition	Tracking lost-to-follow-up cases	Government income generation support	Social protection support	Social support for children	Legal aid
2009–2010	498	53	75	84		7
2010–2011	518	145	23	26	158	
2011–2012	1,883	95	24	745		14

an increase in the number being tested, repeat testing, and changes in surveillance methods. The implementation of the DCA clearly facilitated access to and use of services, and may have contributed to a reduction in the prevalence of HIV in the two districts, but this is impossible to document directly.

## What Worked Well

**Building social capital and empowering communities:** Implementing the DCA entailed decentralizing and mainstreaming HIV management at the district and village levels while empowering local communities to address HIV. In line with NACP guidance, the DCA initiative helped to build knowledge about health, especially HIV and STIs, while building the capacity of high-risk groups to address their own health concerns. Link workers sensitized communities to HIV concerns within the reality of their village or block. Informal groups were formed within high-risk groups, and among youth and women, to help sustain the momentum created.

The accomplishments of the link workers merit special mention given their critical contribution to increased access to services in rural areas. The Link Workers Scheme, given its reach and focus on youth, can go a long way in building social capital and can be a resource for the management of not only of HIV, but also any communicable disease.

**Strengthening infrastructure and institutional care:** For change to occur, it must

be feasible to utilize existing infrastructure and institutional arrangements for health and other social support services. By mobilizing trained human resources at different levels within the district, the DCA was able to identify and resolve bottlenecks in HIV management. Networking and participatory action made it possible to improve the quality of HIV services, and was a major factor in making services more accessible to the target groups. Such tactics as coordinating client visits, providing informal support, and identifying a contact person for emergencies have proved extremely useful.

The social support delivered during the promotional camps provided numerous benefits. Interacting with different government officials under one roof was a new experience for PLHIV. The benefits resulting from the government schemes led to a marked change in the interaction between government officials and the target population, creating a scope for strengthening services even outside the camp setting.

**Enhancing understanding of local high-risk groups:** The manner in which stigma and discrimination occurs depends on the local situation and existing beliefs and fears associated with HIV infection. By implementing a range of HIV interventions at the local level, the DCA captured the dynamics that help or hinder HIV management in specific settings. This type of information can enhance the relevance of HIV interventions. One example is the dilemma in dealing with sexual health concerns among marginal groups such as FSWs. Female sex workers are reluctant to

approach doctors regarding STI concerns due to fear of being judged, and instead use herbal medicine or home remedies which can be obtained without calling attention to their specific health concern. Reluctance of FSWs to seek care was addressed through the health camps which offered a platform for marginal group members to interact with health care professionals in a protective atmosphere without fear of being discriminated against. Prejudice among health care professionals was addressed by the DCA through conducting orientation programs for health professionals on managing health concerns of marginal groups such as FSWs and MSM. This process created greater acceptance and willingness to utilize STI care services. In addition, the DCA also facilitated the distribution of condoms through non-traditional outlets, such as barbershops and even vegetable vendors in areas known as hot spots frequented by FSWs or their clients.

### **Men who have sex with men and violation of rights:**

Preventive programs that address the local causes of discrimination, as well as the fears of hidden MSM and their families, are critical to bringing about change. When local nongovernmental organizations in Nagpur and Aurangabad identified instances of human rights violations or insensitivity by hired thugs (known as *goondas*), sex worker clients, or the police force, the DCA facilitated sensitization of police officials, created a platform to raise concerns about rights violations, and strengthened the dissemination of information on differential sexual orientation across the health care system and the community. MSM reported that they were made aware of who to contact in the event of violence, and that police have become more receptive to their concerns.

### **People living with HIV and their rights:**

PLHIV and their families, especially women and children and those with limited resources or knowledge of their rights, face harsh stigma and discrimination, and addressing this stigma requires

understanding of the underlying context. Link workers, volunteers, and various self-help groups identified discriminatory practices, such as limiting contact with an infected person or family member, or refusing to recognize widows' or orphans' rights to inheritance. The DCA addressed these discriminatory practices through such measures as informal meetings with important family members, the HIV-positive person, and a close relative who could play a role in changing the situation. These sessions might involve identifying fears about HIV and facilitating interactions between the HIV-positive person and a family member, with the goal of bringing the HIV-positive individual out of isolation and back into the family.

**Creating an enabling environment:** Building social capital to improve HIV management is a process. Selecting empowered groups such as link workers, youth groups such as Red Ribbon Clubs that are focused on addressing HIV, or women's groups is only a part of creating an enabling environment; there must be a series of actions that allow these groups to use their skills to generate change. The DCA supported several principles essential to creating an enabling environment.

- Building from a base of knowledge: the DCA employed various strategies and actors to collect and analyze information about the local context. Using information drawn from details about the population, demographics, and the physical and cultural terrain, the Avert Society sensitized different groups who could serve as agents of social change, and trained them to take proactive measures to promote change.
- Facilitating local-level intervention: once trained, agents of social capital receive support for planning and implementation from agencies that are part of the DCA. Some of the interventions include activities in health care, communication on safe sex practices and condom use, nutrition, welfare, and legal services.

- Training to support caring: central to creating and sustaining an enabling environment is sensitivity, which calls for training to assess each case and having the skills to provide or guide clients to the appropriate services. This is especially relevant for ensuring high-quality treatment and respect for human rights.

The DCA has played a crucial role in creating an enabling environment to address HIV concerns at the village, block, and district levels. That was made possible through participatory action that brought together communities and diverse agencies whose joint efforts resulted in HIV management for the district as a single unit.

**Developing a process for documentation and communication:** The Avert Society developed a system of monitoring and documentation, with local agencies playing a major role. The DCA process strengthened the system by identifying duplication of cases and gaps in services, and by documenting the experience of clients who sought care, which made it possible to improve the quality and timeliness of services. The improved monitoring system helped to identify problems with human rights violations and services for orphans and vulnerable children, resulting in a stronger programmatic focus on these issues.

## Challenges

**Transforming fear and alienation to positive action:** HIV invokes fear in the minds of people, a natural response given that early awareness programs on HIV—during the early days of the epidemic—highlighted a threat to life. The next focus of preventive measures dwelt on the taboo subject of sex and sexuality, giving rise to stigma in addition to fear. Thus, at the present stage of intervention, the DCA must translate fear and discomfort to positive action. To make this change, the community needs to see that PLHIV are active

in managing their own lives and that they carry out their daily routines over a long period of time. This can be made possible only by strengthening treatment and other support services for PLHIV.

**Condom use:** Preventive interventions and knowledge on their own will not increase condom use, which is determined by individual circumstances and the negative impressions attached to condom use. According to FSWs, female condoms offer women a chance to have safe sex, and home-based sex workers generally prefer them, but it is the situational reality that determines their use. Interventions and discussions with link workers show that women who work outside the brothel system and engage temporarily in sex work are unwilling to carry condoms. These women need easy access to condoms close to hotspots, either through nontraditional outlets or peers. MSM overall accept condom use, but some MSM who earn an income from sex will have unprotected sex for a higher price, whereas other MSM avoid using condoms with regular partners as a way to indicate trust.

**Addressing mental health and motivation for people living with HIV:** PLHIV undergo personal trauma when confronted with the fact that they are HIV-positive. In some instances, people become nonresponsive or slip into depression. Counselors are equipped to deal with emotionally stressed individuals, but extreme forms of depression call for specialized care. Another issue of concern is non-adherence to ART care; loss to follow-up is especially high among single men.

## Limitations of the DCA

The DCA must function within the limits of local contextual realities to remain viable and relevant to HIV management.

- The DCA can only build on existing human and infrastructural resources, employing and adapting

them to carry out its role within the scheme of national development. Otherwise, the approach would function merely as a tool for identifying gaps in support and service within the district.

- The DCA requires a capacity for flexibility and innovation to enable the implementation of sustainable options, which implies that the key individuals and agencies involved can play a central role in its success.
- The DCA focuses on building institutional linkages and networking, but an excessive focus on institutionalizing the approach can jeopardize its success.

## Recommendations

**Strengthen participatory ownership and sustainability:** By developing a platform that allows a range of actors to coordinate, network, and collaborate, the DCA has ensured the availability of comprehensive, accessible services for those who need them most. Often, an individual, a district official, or community leader plays a critical role in facilitating diverse interventions. However, ensuring sustainability requires that the entire system be sensitive to the complexities of HIV management, so that service delivery is not dependent on a single person. Ensuring that communities and institutions “own” the effort to eradicate HIV requires specific actions:

- Sensitizing institutions involved in services for health, welfare, education, empowerment and justice, and governance.
- Empowering PLHIV, their families, and communities to manage HIV individually and within the community.
- Creating informal helping networks at the village level to mobilize youth, self-help groups,

community-based organizations, and the staff of government agencies to identify and address local issues related to HIV.

- Collating and disseminating data at different contact points to provide communities with intervention findings and to facilitate participation.
- Strengthening local agencies and initiatives for mainstreaming and networking, to ensure the sustainability of DCA’s holistic focus.

Several other principles are important to ensure a holistic response to HIV, as well as to other health and social challenges:

**Develop local initiatives:** The management of communicable diseases requires sensitivity to the local context. In interventions targeting FSWs, MSM, and other high-risk groups, the intervention staff can play an important role in identifying specific needs; in rural communities, link workers can take this role. Interventions should always be based on what the local community needs, and should include provisions to protect human rights and privacy. In addition, it is essential to document the initiatives developed and synthesize the information collected. It is also useful to integrate lessons learned within community prevention programs through street plays or locally created media.

Developing approaches that reflect the true needs of the community can take time. For example, one link worker developed his own method of network analysis and used it to identify 13 positive cases within a village social network. The process of observation, identifying probable close ties, and facilitating testing took seven months.

**Keep focusing on stigma:** Stigmatization, or de-stigmatization, is a process and not a one-time event. When confronted with the threat of communicable disease, a society’s initial reaction is to identify and denounce any apparent deviation from the norm—for example, the behavior of FSWs

and MSM. Approaches like the Link Workers Scheme, being based on close interaction with local communities, can play a powerful role in reducing stigma, and also in linking PLHIV with the service and support networks created through the DCA.

Children who have HIV bear the heaviest burden of stigma from HIV. It is important for HIV program managers to address discrimination against these children and to look at ways to integrate them within the community and to prevent social isolation. Here, the DCA can play an important role through its broad reach among communities and institutions, and through its capacity for networking.

**Conduct research:** Addressing HIV in terms of specific contexts requires both qualitative and quantitative research that can point to appropriate approaches and can identify service weaknesses. Research findings should be made available and reported back to the communities and institutions that participated.

**Create helping networks:** Fundamental to the DCA and its sustainability is the availability of a pool of sensitive and knowledgeable individuals from various groups, such as women and youth, who are willing to play a role in providing HIV services. Such a network can be useful in other types of care, or emergencies such as natural disasters. Creating or participating in helping networks can benefit those who take part—for example, by sensitizing urban participants to the realities of rural life. Also, by bringing together people from different backgrounds, helping networks can represent a step toward fuller utilization of India's greatest wealth—its people.

## Future Programming

The District Comprehensive Approach can play a central role in facilitating HIV management because it gives scope for sustaining decentralization

and ensuring participatory, collective action. Although there are plans to replicate the DCA in other districts, replication has not yet begun. Steps for scaling up DCA need to be in line with the NACP Phase IV, which focuses on using an inclusive, participatory, and consultative approach to address concerns about HIV, especially among high-risk and vulnerable groups. Sustainability for DCA would require District AIDS Prevention and Control Units to take on an active role because it is present throughout Maharashtra. Coordination at district levels can be strengthened by block-level committees consisting of individuals and agencies, provided that they are well-oriented on the approach. A central tenet for successfully implementing the DCA is a participatory approach that can adapt to the input and insights of partner agencies on the specific needs of high-risk groups and vulnerable populations at the block or district level. ■

## REFERENCES

- Avert Society. 2008. *HIV/AIDS Communication Strategy and Implementation Plan, Aurangabad District, Maharashtra*. Mumbai: Avert Society.
- Avert Society. 2010a. *HIV Risk Behavioral Surveillance Survey in Maharashtra Wave IV*. Mumbai: Avert Society.
- Avert Society. 2010b. *HIV Risk Behavioral Surveillance Survey in Maharashtra Wave V*. Mumbai: Avert Society.
- Fuller, Andrew. 2003. *Supporting Community Responses to HIV/AIDS in Zambia*. Boston: JSI.
- Gulu District Local Government. 2008. *HIV/AIDS Strategic Plan (2009–2012)*. Gulu: Gulu District Local Government.
- National AIDS Control Organisation. 2006. *National AIDS Control Programme Phase III 2006–2011*. New Delhi: Ministry of Health and Family Welfare, Government of India.
- National AIDS Control Organisation. 2009. *Link Worker Scheme Operational Guidelines*. New Delhi: NACO.

Available at <http://nacoonline.org/upload/Link%20Worker%20Scheme/Operational%20Guidelines-LWS.pdf> (accessed March 2012).

National AIDS Control Organisation. 2011a. *National AIDS Control Programme Phase III: State Fact Sheets, March 2011*. New Delhi: Ministry of Health and Family Welfare, Government of India.

National AIDS Control Organisation. 2011b. "National AIDS Control Programme Phase IV Planning Process." Available at [http://nacoonline.org/NACP-IV/National\\_AIDS\\_Control\\_Programme\\_Phase\\_IV/NACP\\_IV\\_Planning\\_process/](http://nacoonline.org/NACP-IV/National_AIDS_Control_Programme_Phase_IV/NACP_IV_Planning_process/) (accessed March 2012).

United Nations Children's Fund. 2003. *Helping Communities to Take Charge—A Process Documentation on Microplanning*. Mumbai: United Nations Children's Fund.

## RESOURCES

Avert Society: [www.avertsociety.org](http://www.avertsociety.org)

John Snow, Inc.: [www.jsi.com](http://www.jsi.com)

Mumbai District AIDS Control Society: [www.mdacs.org](http://www.mdacs.org)

National AIDS Control Organisation: [www.nacoonline.org/NACO](http://www.nacoonline.org/NACO)

U.S. Agency for International Development/India: [www.usaid.gov.in](http://www.usaid.gov.in)

Joint United Nations Programme on HIV/AIDS/India: [www.unaids.org.in](http://www.unaids.org.in)

## ACKNOWLEDGMENTS

The author would like to thank Dr. David Hausner, Country Director, AIDSTAR-One, for the support extended at every stage of documentation and finalization of the document. Dr. Sangeeta Kaul and Sampath Kumar, with the U.S. Agency for International Development, provided valuable input on the documentation process, especially at the stage of conceptualization. This exploration of issues linked to HIV management and stigmatization was made possible by the willingness of those infected and affected by HIV to share their inner spaces; the author

expresses gratitude to all of them. The journey, from beginning to end, remains the outcome of the insights, documents, and experiential details provided by the staff of the Avert Society: special thanks to Smriti Acharya, Anna Joy, Dr. Anjana Palve, Amita Abichandani, Arupa Shukla, Hemant Bhosale, Sidharth Bhotmange, Nitin Bhowate, and Dr. Rajrattan Lokhande. The author would also like to thank the partner nongovernmental organizations of the Avert Society who shared their knowledge and guided the process of understanding the relevance of the District Comprehensive Approach. The author wishes to thank Marathawada Gramin Vikas Sanstha; Prerana Samajik Sanstha; Gram Vikas Sanstha; Gramin Vikas Mandal; UDAAN, CRT & RI; Dr. Babasaheb Ambedkar Vaidyakiya Pratisthan in Aurangabad and Sarathi; Bharatiya Adim Jati Sevak Sangh; the Comprehensive Rural Tribal Welfare Development Programme; the Indian Institute of Youth Welfare; the Indian Red Cross Society; and the Young Men's Christian Association in Nagpur for their insights. Dr. S. S. Kudalkar, representing the Mumbai Districts AIDS Control Society, facilitated the process by giving an overview of government initiatives. True to the spirit of implementing the District Level Comprehensive Approach, the staff at the District AIDS Prevention Control Unit and the government agencies gave their full support at all stages of the documentation process. Their valuable inputs are appreciated. Thanks are due to Ruchi Lall for editing the initial draft and to Stephanie Joyce for the final edit.

## RECOMMENDED CITATION

Charles, Molly. 2012. *District Comprehensive Approach for HIV Prevention and Continuum of Care in Maharashtra, India*. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

**Please visit [www.AIDSTAR-One.com](http://www.AIDSTAR-One.com) for additional AIDSTAR-One case studies and other HIV- and AIDS-related resources.**



**AIDSTAR-One's Case Studies provide insight into innovative HIV programs and approaches around the world. These engaging case studies are designed for HIV program planners and implementers, documenting the steps from idea to intervention and from research to practice.**

**Please sign up at [www.AIDSTAR-One.com](http://www.AIDSTAR-One.com) to receive notification of HIV-related resources, including additional case studies focused on emerging issues in HIV prevention, treatment, testing and counseling, care and support, gender integration and more.**