National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

आज़ादी का अमृत महोत्सव

Capacity Building of Communities, Community Networks, and CSOs

Module - 4
Demand Generation

Community System Strengthening under NACP - V

Module - 4
Demand Generation

सत्यमेव जयते

वी. हेकाली झिमोमी, भा.प्र.से.
अपर सचिव एवं महानिदेशक
V. Hekali Zhimomi, IAS
Additional Secretary & Director General

आज़ादी का अमृत महोत्सव

AIDS Helpline 1097
जानें समझें, जुग-जुग जीयें!

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

Foreword

NACP Phase-V envisages "Keep beneficiary and community in center" of HIV/AIDS epidemic as one of the key guiding principles. This aims to maximum the benefits to its diverse target population in a friendly ecosystem, offering a basket of tailored integrated services across prevention-detection-treatment spectrum. The National AIDS Control Program acknowledges the collaboration and involvement of the communities, people living with HIV/AIDS and civil society organizations as key to elimination of HIV/AIDS related stigma and discrimination and strengthening the HIV response in the country. Under NACP V, Community Systems Strengthening (CSS) as an approach complements NACO's overall vision where every person who is highly vulnerable to HIV is heard and reached out to and every person living with HIV is treated with dignity with access to quality care.

Under CSS, the aim is to identify and build the capacity of the communities, community networks and community organisations to ensure greater meaningful involvement of communities (and their organisations) in planning, implementing, monitoring, and evaluation of NACP. It is expected that these individuals, groups and networks from the community will complement the program through mobilizing the community, increasing demand for NACP services and support in improving the quality of care. NACO, through the model of social contracting already partners with Non-Governmental Organisation (NGOs) and Community Based Organisations (CBOs) for provision of HIV services to our priority populations, and hence, it is envisioned that through further capacity building efforts more community-based organisations will be able to take this partnership to the next level.

The capacity building modules developed under CSS, are designed to equip community, community networks and community-based organisations with the necessary knowledge, skills and tools to augment the HIV response in India. I believe these modules will play a valuable role in increasing the capacities of our communities to work in partnership with the National Program towards achieving the goal of elimination of HIV as a public health threat by 2023.

(V. HEKALI ZHIMOMI)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel.: 011-23325331 Fax : 011-23351700
E-mail : dgoffice@naco.gov.in

निधि केसरवानी, भा.प्र.से.
निदेशक
Nidhi Kesarwani, I.A.S.
Director

सत्यमेव जयते

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

Preface

NACP recognizes the need for community-engaged responses, not just as beneficiaries, but as key partners in action for improving health and well-being. It aims towards elimination of HIV/AIDS related stigma and discrimination. NACP Phase-V, therefore aims to institutionalize the community engagement and meaningful participation at the most granular level in the form of community system strengthening (CSS). CSS will catalase improved health outcomes specifically through strengthening targeted interventions (TI) program, advocacy and rapid response to reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

Under CSS, creation of the community resource pool at the national and sub-national level is given priority wherein focus is to increase capacities of community, community networks and community based organisations. This is done with the objective to enhance engagement and participation of the community in all aspects of the national program from planning, implementation and monitoring. More recently, substantial contribution is added by the community when engaged through community advisory boards at the district level. while conducting Programmatic Mapping and Size Estimation. Through the principles of GIPA, NACP also recognizes the involvement of PLHIV and affected communities by enabling individuals and communities to draw on their life experiences; thus contributing to reducing stigma and discrimination. Communities also play an pivotal role in enactment of the HIV/AIDS Act 2017 by increasing awareness and creating accountability for furthering the HIV response in the country.

Aligned with the above, the modules have been developed for "Capacity Building of Communities, Community Networks and CSOs" under CSS as part of the Global Fund grant, 2021 – 24. It is intended to intensifies efforts for building capacity and human resources, with the aim of enabling communities and community actors to play a full and effective role alongside health and social welfare systems. The modules are useful not only for the HIV program but can also be referenced by the larger public health programs towards effective community engagement in the country.

(Nidhi Kesarwani)

9th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel. : 011-23325343
E-mail : dir@naco.gov.in

AIDS Helpline 1097
जानें समझें, जुग-जुग जीयें!

Dr. Anoop Kumar Puri
MBBS, MD
Deputy Director General
Tel.: +91-11-23731805
Fax : +91-11-23731746
Mob. : 9868143711
E-mail : anoopk.puri@nic.in
ddgcstnaco@gmail.com
ddgieenaco@gmail.com

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
स्वास्थ्य और परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
छठा तल, चन्द्रलोक बिल्डिंग, 36, जनपथ,
नई दिल्ली - 110001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
6th Floor, Chandralok Building,
36, Janpath, New Delhi - 110001

Message

The fifth phase of the National AIDS Control Programme, aims to attain the United Nations' Sustainable Development Goals 3.3 of ending the HIV/AIDS epidemic as a public health threat by 2030. This has warranted a focused and stronger attention to community involvement in the HIV response in India. Therefore, community system strengthening lays strong emphasis on building capacity and human resources, with the aim of enabling communities and community actors into full partnership with national health and social welfare systems.

There are new overarching strategies that are employed under NACP phase V which complement ensuring access to testing, treatment and care services. There is attention on developing new generation and integrated communication strategy for prevention, testing, and treatment of HIV and STIs. Focus is also laid on promoting launch and scale-up of social protection schemes by Central/State Governments to mainstream people infected and affected with HIV, including the vulnerable population, towards reducing inequalities and promoting inclusions. To reduce HIV related stigma and discrimination, emphasis is on accelerating the notification of State rules in context of the HIV and AIDS (Prevention and Control) Act, 2017, which is the primary legislation protecting and promoting the rights of people infected and affected with HIV. The community of key population and PLHIV will play an important role by spreading awareness, generating demand and supporting in creating an enabling environment for implementation of these strategies, especially by strengthening the process of grievance redressal mechanism.

These modules support in ensuring that information regarding the rights of the community, access to correct and relevant information regarding the programs under NACP and information on social welfare and protection schemes reaches our priority population. Under CSS, the creation of a community resource pool will complement the National level efforts to accelerate and sustain the national HIV response.

(Dr. Anoop Kumar Puri)

डॉ. शोभिनी राजन
मुख्य चिकित्सा अधिकारी (एसएजी)
Dr. Shobini Rajan, M.D. (Pathology)
Chief Medical Officer (SAG)
Tel. : +91-11-23731810, 43509956
Fax : +91-11-23731746
E-mail : shobini@naco.gov.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
9वां तल, चन्द्रलोक बिल्डिंग,
36, जनपथ, नई दिल्ली-110 001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
9th Floor, Chandralok Building,
36, Janpath, New Delhi - 110 001

Message

Under NACP phase V, NACO's vision for community system strengthening (CSS) is to ensure meaningful involvement of PLHIV and Key Populations to support the ongoing HIV interventions by building communities capacities and their systems. It is envisioned as an important strategy to improve the program's impact; effectiveness, efficiency, and accountability through better collaboration. It is envisioned for building capacities for reaching the unreached and hidden groups, dissemination of information, and creating an enabling environment for the reduction of stigma and discrimination.

One of the main components of CSS, is to identify and build the capacities of communities, community networks and organizations, it was envisioned to develop capacity building modules based on the needs of the community. As NACO has always involved the community through constant consultation and conversation, the same process has been followed for the development of the above. The topics covered were identified through the mechanism of community needs assessment and finalized through consultation meetings. The 6 thematic areas identified for the modules are: Advocacy; Community networks, linkages, partnerships, and coordination; Resources Mobilization; Demand Generation; Organizational and leadership strengthening; and CLM & Knowledge Management.

The modules for "Capacity Building of Communities, Community Networks and CSOs" are developed covering a range of topics that can be utilised by stakeholders like SACS and implementing partners working with community, community groups and organisations but also for the communities themselves to increase their knowledge and skills to contribute towards the National HIV program. I believe these modules will contribute to strengthening the roles of our priority populations to achieve the highest attainable standards of health, no matter who they are or where they live.

(Dr. Shobini Rajan)

डॉ. भवानी सिंह कुशवाह, एमडी
उपनिदेशक
Dr. Bhawani Singh Kushwaha, MD
Deputy Director

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

Acknowledgment

We strongly believe that the modules developed for "Capacity Building of Communities, Community Networks and CSOs" under CSS as part of the Global Fund grant (2021 – 24) under NACP V will intensify NACO's efforts towards meaningful engagement of the communities in the National HIV response in India.

We are grateful for the valuable guidance provided by Ms. V. Hekali Zhimomi (Additional Secretary & Director General, NACO). Ms. Nidhi Kesarwani (Director, NACO) provided her valuable experience in defining the content for the modules. Dr. Anoop Kumar Puri, (DDG – CST, IEC & MS, NACO), Dr. Uday Bhanu Das (DDG – PMR & Lab Services, NACO) Dr. Shobini Rajan (DDG – TI, BSD and STI, NACO), Dr. Chinmoyee Das (ADG – CST, SI & IT, NACO), Dr. Bhawna Rao (DD – IEC & MS & Lab Services, NACO) and Dr. Saiprasad Bhavsar (DD – CST, PMR & SCM, NACO) and SACS officials for their technical inputs and contribution in developing the modules.

We take this opportunity to acknowledge the efforts of Dr. Shantanu Kumar Purohit (NC- Prevention), Ms. Nidhi Rawat (NC – IEC), Ms. Vinita Verma (NC – SI), Mr. Utpal Das (Consultant – IEC & MS), Ms. Smita Mishra (Consultant – Lab Services), Mr. Rahul Ahuja (AC – Prevention), Ms. Ira Madan (TE – CSS), Dr. Benu Bhatia (PMU – GF), and Mr Rohit Sarkar (TE – Prevention).

We extend our appreciation towards all the community representatives, members and experts from the CSS National Working Group, community networks and CBOs for providing their community perspective and ground experience in shaping the topics covered in the modules. We duly acknowledge the role of our development partners i.e. India HIV/AIDS Alliance, The Humsafar Trust, Plan India, YRG Care, SWASTI, FHI360, I-Tech India, VHS, PATH, JHU and bilateral partners i.e. UNAIDS, USAID, CDC and WHO.

We also thank the consultants, Ms. Alpana Dange and Ms. Sukanya Poddar (PIP) for developing the modules. Lastly, we are grateful to the PMU for CSS i.e. Dr. Narendra Kumar Jangid, Mr. Vikash Singh, Mr. Dayanand Kumar Gupta, and Mr. Vikas Kurne with special reference to the leadership provided by Dr. Sangita Pandey (HLFPPT) for their significant role in the successful development of the capacity building modules.

(Dr. Bhawani Singh)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel. : +91-11-43509993 M.: +91-9792101700
E-mail : bhawani@naco.gov.in; drbhawani.naco@gmail.com; Website : www.naco.gov.in

Contents

Table of Contents

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organization
CC	Community Champions
CSC	Care and Support Centers
CSS	Community Systems Strengthening
CHW	Community Health Worker
CAP	College of American Pathologists
DAPCU	District AIDS Prevention and Control Unit
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HIV-ST	Human Immunodeficiency Virus-Self Testing
H/TG	Hijra/ Transgender
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centres
IEC	Information, Education and Communication
KM	Knowledge Management
KP	Key Populations
MSM	Men Having Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS & STD Control Programme
NGO	Non-Government Organization
OST	Opioid Substitution Therapy
OR	Operating Room
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
PrEP	Pre-Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
POCT	Point of Care Testing
SACS	State AIDS Control Society
TI	Targeted Intervention
WHO	World Health Organization

CHAPTER - 1.0
Introduction, Background and Overview

India is one of the countries in the Asia Pacific region that have recorded significant decreases in new infections among the key populations (KP) and significant increase in providing access to treatment among people living with HIV infection. The strategies adopted by the National AIDS Control Organization (NACO) for prevention, treatment and care have predominantly worked because the National AIDS & STD Control Programme (NACP) has kept the key populations (KP) and people living with HIV (PLHIV) at the center of its response. Working with the key groups, consulting and respecting them as the stakeholders have supported immensely in advancing the response to combat HIV/AIDS and the social ramifications of the epidemic. India in its' fight to end AIDS is at a critical juncture as the fast- track targets and India's commitment to end AIDS by 2030, warrants focused and stronger response from the key players. The key players in this regard are the community members from the key populations such as the female sex workers (FSW), men having sex with men (MSM) and PLHIV. Participation and leadership of the key players from KPs in tandem with a well-integrated national program will take India towards achieving the global goals of ending AIDS by 2030. Towards this purpose the NACP V focuses on Community System Strengthening (CSS) and empowerment and calls for community engagement at different level including cadre of health delivery system, at both NACO and State AIDS Control Society (SACS) level. Community System Strengthening aims to achieve improved health outcomes of NACP specifically for strengthening targeted interventions (TI) program, reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

One of the main approaches under Community System Strengthening is to develop the capacities of communities and Community Based Organizations (CBO) and Non-Government Organization (NGO). In the year 2021, NACO conducted a series of consultations with the community members and national level stakeholders. These consultations pointed out towards the capacity strengthening needs of the community. The national level consultation also brought out the thematic areas on which training could be imparted. Therefore, in order to develop the capacities of individuals and community-based organizations, module-based trainings have been envisaged. This module and other five modules have created to address the related learning needs of the Community Champions (CCs) and CBOs/NGOs in the field of HIV/AIDS prevention program.

CHAPTER - 2.0
Purpose of Module: 4
Demand Generation

Community representatives, CBOs and NGOs have played a key role in informing and facilitating access to services for the KPs. Due to their lived experiences and connect at the grass root level, they continue to be in a unique position to inform the KPs about quality and free HIV prevention and services. The purpose of this module is to strengthen the understanding of participants towards existing gaps, bridging the gap by generating demand for services.

Target Audience of this module

The target audience of this module are the Community Champions and CBOs/NGOs representing and/ or working for the Key Populations (KPs). The key populations who are defined under the Global Fund CSS framework are those groups that meet all three of the criteria below:

1. The population experiences increased risk or burden of disease due to a combination of biological, socio-economic and structural factors;
2. Access to health services that prevent, diagnose, treat, or care for these diseases is lower than for the general population; and
3. The population experiences human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization.
   Based on the above criteria, the KPs are defined by NACO as under:

Female Sex Worker (FSW)

Adult women who engaged in consensual sexin exchange for money/ payment in kind at least once as a means of livelihood in the last six months.

Men having sex with men (MSM)

Adult men who had anal or oral sex with more than one male/hijra partner at least once in the last six months.

Hijra/ Transgender People (H/TG)

Sexually active adult person having more than one sexual partner in the last six months and whose self-identity does not confirm unambiguously to conventional notions of male or female gender roles but combines or moves between these.

People who inject drugs (PWID)

Adult men and women who use addictive substances for recreational or non- medical reasons, through injections, at least once in the last six months.

People Living with HIV (PLHIV)

People Living with HIV who require anti-retroviral therapy (ART) to live a healthy life.

The Community Champions and representatives of CBO/NGO may be from these KPs and some of them may also from the general population. They will constitute the training participants whose capacities will be strengthened under the CSS.

CHAPTER - 3.0
Objectives of Training Module: 4 Demand Generation

The master trainers need to bear in mind that the participants are Community Champions and the representatives of a CBO/NGO who have a key role to play towards demand generation and service uptake hence need to develop key skills in that area. Therefore, the objective of this training module are as under:

1. To ensure service accessibility to all who need them, evidence-informed and based on improved knowledge.

CHAPTER - 4.0
Expected Outcomes

It is expected that after the training, workshop participants will have better understanding of the community activities and service delivery. The overall outcomes are as under:

1. Identify the gaps pertaining to KP and PLHIV.
2. Learn to fill up the gaps by taking action towards facilitating access to quality services.

CHAPTER - 5.0
Principles of the Training Program

The participants of the workshop will be CBO/NGO professionals, activists and community resource persons with varying experience and education. The approaches used for the module cannot be a mere class room lectures kind of one-way interaction; it has to be an approach that respects as well as incorporates their experience, pre-existing knowledge and motivates them to adapt the new learning. Hence, the adult learning approach known as the Andragogy will be utilized for developing these modules. According to Malcom Knowles, an eminent exponent of the adult learning enunciated following core principles of andragogy are:

1. Adults ***need to know*** why they need to learn something before learning it.
2. The ***self-concept of adult*** is heavily dependent upon a move towards ***self -direction.***
3. ***Prior experiences*** of the learner provide a rich ***resource for learning.***
4. Adults typically become ***ready to learn*** when they ***experience a need to cope*** with a life situation or perform a task.
5. Adult orientation to learning is life centered and they see ***education as a process of developing increased competency levels to achieve their full potential.***
6. The ***motivation for adult learners*** is internal rather than external.

Andragogy reorients adult educators from “educating people to helping them learn”. The methods used may range from isolated instruction within a curriculum or integrated instruction. It may also encompass intentional and unintentional learning situations. The instructions need to be organized by task and present in a manner similar to how it will be used . The learner needs to know why the concept to be learned is important in order for the learner to remain motivated. Despite the learner ultimately having control of learning through self-directed means, the trainer needsto facilitate the opportunities for the learner to experience growth.

CHAPTER - 6.0
Methods of the Training Program

The module covers the subject in great details. The facilitator is required to study the content and if need be research it further and prepare themselves thoroughly. The facilitator can modify presentation to meet the regional need.

This module is further divided into sub-modules with the activities and direct instructions which can be used to explain concepts. During the activity, the facilitator is expected to explain the practical implications of that activity and link it with the content. The facilitator is expected to address specific topics of immediate concern and then expand to how it can be applied in real life situations as well as for various key populations. Much of the content will be applicable to the experiences of the learners therefore a facilitator is expected to engage in active learning, use the learner experience and incorporate key learning on the spot for the better understanding of participants. Facilitator may also engage in cross learning for example learning from the successes of a particular KP group and identifying key strategies that could be incorporated towards other key groups.

CHAPTER - 7.0
Ethics of the Facilitator

Respect for participants

The workshop participants may come from different geographies, life experiences and diverse KP groups. The facilitator needs to be aware about this diversity and respect is the participants. The respect should translate into his/her/their way of verbal and non-verbal communication. A participant's agency should be fully respected by the facilitator.

Being non-judgemental

The facilitator should make him/her/themselves aware about the diversity of their workshop participants and must be non-judgemental towards them. No participant should be judged on the basis of their sexuality, gender identity, sexual behavior, being in sex work and their vulnerability to HIV/AIDS.

Equality towards participants

Over and above being sensitive to the diverse participants, a facilitator is also expected to treat all the participants equally. All participants need to be given equal opportunity participate and express their views. Participants can be of varied personality such as introverts and extroverts, sensors and intuiters, thinkers and feelers, judgers and perceptors. People from all of these personality type needs be given equal opportunities to participate in the workshop.

Respecting Confidentiality

Team building and group work creates a comfort zone for the participants in which participants may share their deeply personal insights and stories. The facilitator has to ensure that post training, they are not sharing these insights by naming any participant. Maintaining confidentiality of the participants and proceedings is an important ethic to be followed by the facilitator.

Module 4	Community Activities and Service Delivery: Demand Generation for Service Uptake
Module Objectives	To ensure service accessibility to all who need them, evidence-informed and based on improved knowledge
Expected Learning Outcomes	**Community Champions and CBOs learn to:** 1. Identify the gaps pertaining to KP and PLHIV 2. Learn to fill up the gaps by taking actions towards facilitating access to quality services.

CHAPTER - 8.0
Session: 4.1 Gap Analysis

Session: 4.1	Gap Analysis
Learning objectives of this session	**Participants learn about:** • How to conduct the gap analysis • Devise action strategies to overcome gaps
Duration	2 Hours
Tools	Power Point Presentation, Case studies, Chart Papers with Pen
Methodology	Lectures, group work

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of gap analysis. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.

Gap Analysis and Action Strategy

Activity: 1 **10 Minutes**

Case Situation

In an urban slum pocket, there are a number of "doctors" who claim to provide treatment and medicines for STIs as also for sexual health problems. Most residents of this community go to these doctors despite the presence of a Municipal Health Clinic nearby and a medical college hospital which can be easily accessed by the Bus by paying minimum fare. The municipal health workers continue to complain about the ignorance of this community who do not cooperate with the health workers during the house-to-house health surveys.

Questions

What seems to be the situation here?
What are the possible reasons for this situation?
What can be done about it?

Activity: 2 — 10 Minutes

Case Situation

In Azamgarh district of Uttar Pradesh, several blocks have families of men who work in different states of India. In a particular village popularly known as "ChotaBambai" (little Mumbai as most families have a member working in Mumbai), there are instances of some workers known to be living with HIV but it is not known if they are on ART. There are rumours that some of their spouses may also be living with HIV. This is also a village where 20 percent of women have home deliveries.

Questions

What seems to be the situation here?
What are the possible reasons for this situation?
What can be done about it?

Allow different groups to share their views on these cases for up to five minutes.

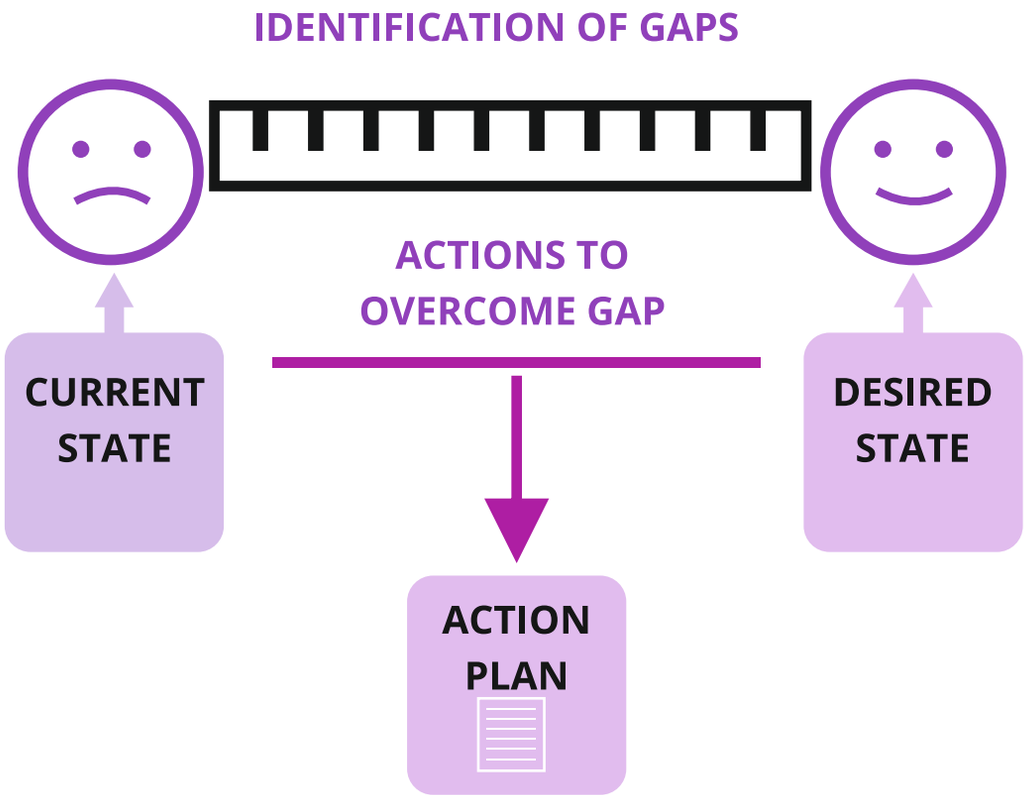
Lecture Content for Facilitator

Understanding Gap Analysis

Gap analysis is about understanding the difference between current state versus desired state. The desired state is based on for example target, data or the scientific-medical standards. The gap, once identified becomes an action area.

To put it simply, if you aimed at distributing 500 condoms in the field but have distributed only 250 then you have a 50 percent gap. This identified gap becomes an action area, which requires you to work further.

Gap Analysis

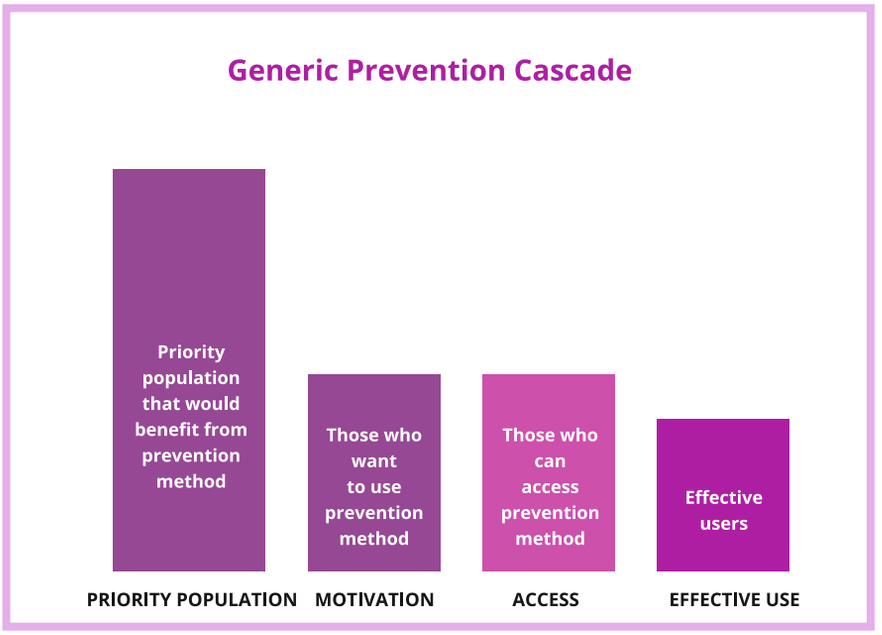


Gap Analysis for HIV Prevention

In order to achieve the targets of 95-95-95, it is important for participants to understand that more and more younger people become sexually active, they may experience social and structural barriers to access prevention services. It is important to analyse the gaps experienced by KP community in your area before preparing an action plan to fill those gaps.

Understanding an easy HIV prevention cascade could be useful for advocates like the community champions and CBOsto understand where the gaps in prevention are and to work towardshighlighting those gaps to DAPCU and working towards filling those gaps if you are a CBO.

Researchers have proposed a generic HIV prevention cascade which recognises that the use of prevention methods is behavioural, affected by social and structural forces. They have given a practical example of how this cascade can be used for a specific method in a specific population – condom use among adult men in a province of eastern Zimbabwe.



- **Population:** 100%. The denominator is HIV-negative men who report multiple, casual or concurrent sexual partners.
- **Motivation:** 33%. A survey showed that the principle gaps in motivation related to perceiving condoms to be socially unacceptable or reducing sexual pleasure.
- **Access:** 33%. In the survey, all men who had motivation to use condoms knew how to obtain them.
- **Effective use:** 17%. Only half of those who had motivation and access reported consistent condom use over the last two weeks. The main explanation of inconsistent use was a lack of partner support. In contrast, very few men reported problems with self-efficacy to use condoms.

A similar cascade for women in the same area highlighted different gaps. Far more women than men were motivated to use condoms, but a lack of partner support was even more important a factor preventing effective use. While most women could access condoms, a few could not.

Identifying the reasons for gaps in the cascade could help in the development of interventions. In this example, community-based interventions to make condoms more socially acceptable would appear to be a priority. Couples counselling and strengthening women's rights might have an impact on effective use.

Schaefer, R., Gregson, S., Fearon, E., Hensen, B., Hallett, T. B., & Hargreaves, J. R. (2019). HIV prevention cascades: a unifying framework to replicate the successes of treatment cascades. The Lancet HIV, 6(1), e60-e66.

HIV Treatment Cascade

The HIV treatment cascade outlines the steps of care that people living with HIV go through from initial diagnosis to achieving viral suppression, and shows the proportion of individuals living with HIV who are engaged at each stage.

When someone is virally suppressed as long as they continue to adhere to their treatment regime, they are likely to be in good health and are unlikely to pass HIV onto anyone else. For both of these reasons, achieving viral suppression, and attending regular viral load monitoring appointments to check that the virus remains suppressed, is the ultimate aim of the HIV treatment cascade.

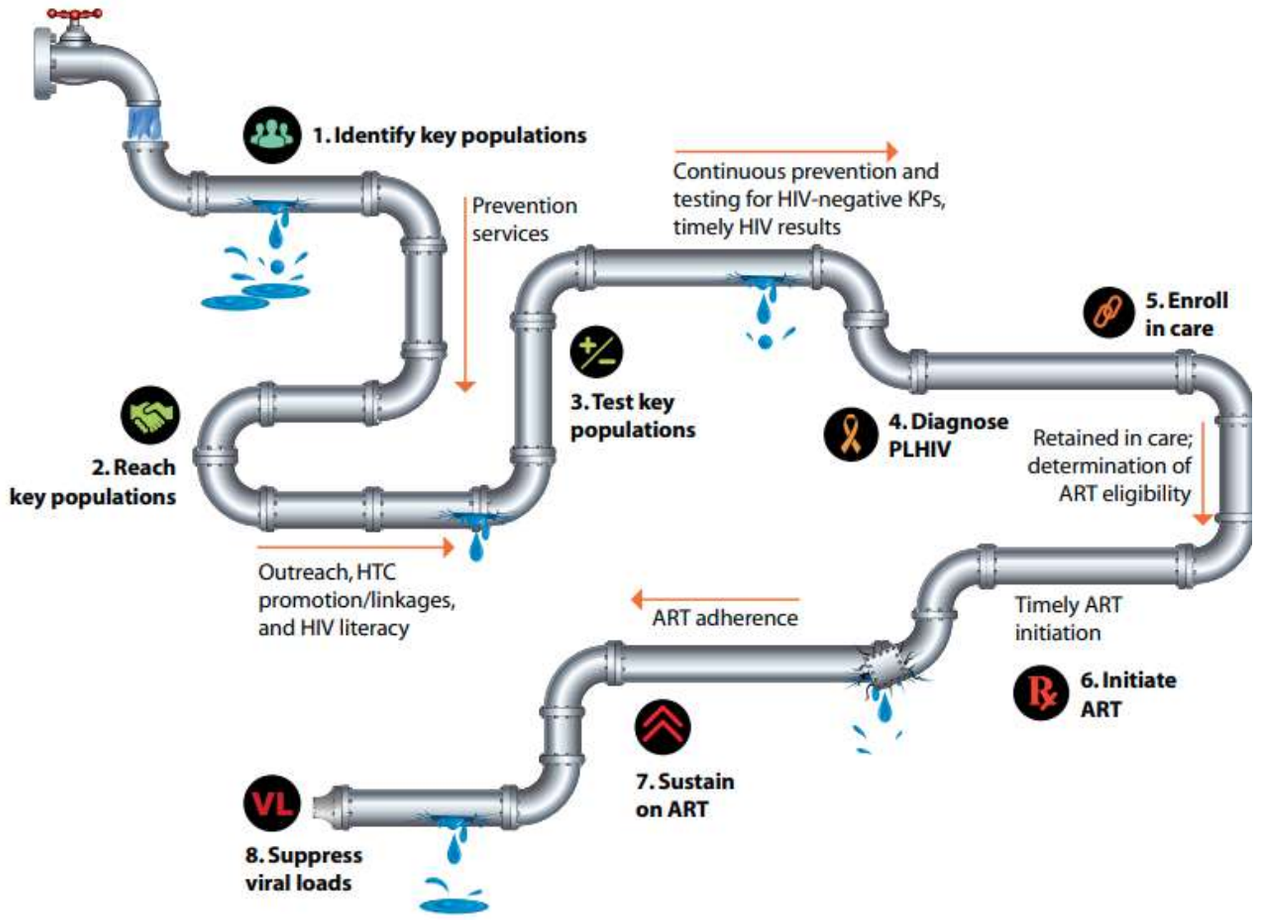
For viral suppression to happen, people living with HIV, once diagnosed and on treatment, need to continuously engage with treatment services, adhere to medication, and have their treatment appropriately managed if they have any difficulties. If any of these steps are missed, the benefits of treatment for the individual, and the prevention benefits for their sexual partners and for the wider population, can be lost.

ART requires tablets to be taken as prescribed, without missing doses. If people do not adhere to this, HIV can mutate, which is when it changes its genetic make-up, and treatment can become ineffective. This means people's viral load will increase and they may pass drug resistant HIV on to others. For this reason a strong treatment cascade is essential for limiting the prevalence of drug resistant HIV.

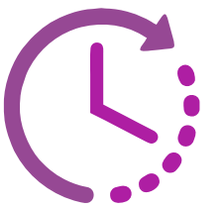
Source:
https://www.avert.org/professionals/hiv-programming/treatment /cascade

Understanding the Leaky Pipe of HIV Cascade

From prevention to care, where the end goal is viral load suppression there is an entire pipeline with a possibility of various leaks. CBOs and Community Champions have to understand these leaks and work/ seek support to fix those.



Source:
HIV Cascade Framework for Key Population, October 2015 USAID, PEPFAR, LINKAGES, FHI 360
https://www.fhi360.org



Activity: 2 — 20 Minutes

Participants may be divided into teams having 4-5 members. Each team is given a chart paper and three sketch pen – blue, red and green. Blue should be used for drawing pipe, red for leaks and green for action required to prepare the HIV Care Cascade's leaky pipe. Where ever the green action is mentioned, asked the participants, who all are required to take action- CBO, TI, SACS, DAPCU or community champions? Allow different groups to share their chart or display their chart.

Lecture Content for Facilitator

Demand Generation

As your analysis of "Leaky Pipe" activity shows that there may gaps because of the following reasons.

- People are not even aware that their behaviors are risky and can have negative (lack of STI/HIV/AIDS and ART knowledge, lack of adherence).
- People are not even aware that there are methods and treatment that can protect them (condoms, STI treatment, ART, PEP and PrEP).
- People are not aware where can they go and seek services like the HIV testing, STI treatment, OST and ART.
- People have heard of the but have their biases and fears regarding the services for example: what if my information is made public, whether the treatment is free or not, will the HCP judge me?
- People have heard of the services but are too poor – they do not have regular income hence cannot spend money on transport. They may not have ration card or livelihood.
- People belonging to marginalised KP group usually experience various legal, social, economic and health beliefs related challenges. They spend considerable time and money in dealing with these challenges hence HIV may not be a huge concern for them.

Demand generation or creation

Demand generation or creation is a process by which a Community Champion, and CBO/NGO understand the need of their community's needs related to HIV and STI transmission and prevention knowledge, risk behaviors, testing and treatment needs. Such a CC/CBO/NGO need to work with such a community, individual to enhance their knowledge and motivate them by various methods such as IEC, BCC and counselling to seek various services. Once a certain demand is created, people may seek services directly or even take help from the Community Champion and CBO/NGO.

Activity: 3 — 15 Minutes

Demand Generation Simulation Exercise

Things required: White and Pink Satin Ribbon rolls.
Let's learn how to generate demand by doing it.
We need three sets of volunteers for this:

Group: 1 Services

Instruction

Volunteers who are representing officials from DAPCU or program division will be on one side. Please take a chart paper and label yourself as services.
The Challenge: You are offering services but hardly people are coming. It's a concern for this group.
Group: 2 KP

Instruction

KP Community needing information and services like the knowledge on HIV prevention, condom, OST, STI treatment, HIV Testing, ART, social support. Volunteers who are in KP group will write their service needs on a paper and display it.

The Challenge

Many of the KP members are experiencing challenges and do not know how and from where to get the services from.

Group: 3 Community Champion and CBO/NGO

Some have to volunteer as community champion (1) and some people have to play as a CBO/NGO.

The challenge

Engaging in demand generation activities.
Community Champion and CBO/ NGO have to plan and engage in demand generation activity.

Instructions to KP community:

As and when a Community Champion or CBO approaches you and tells you about the service information and if it appeals to you, you go to the service side and stand next to the service. If this information does not appeal to you then you remain where you are.

Discussion on simulation

Analyze the demand generation activities conducted by the Community Champions and CBO/NGO.

Then discuss with those volunteers who moved to service side, why did they seek that service.

Then discuss with those who did not move as to why they did not seek services.

Based on their responses you understand what worked in demand generation and what did not work.

Alternate Activity: 3 — 10 Minutes

Discuss among your group and list down the needs of KPs and what strategies would you use to generate demand.

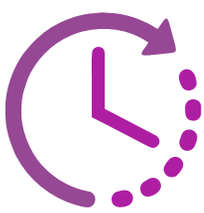
Kps	Needs	Strategy To Generate Demand
FSW		
MSM		
TGW		
PWID		
PLHIV		

CHAPTER - 9.0
Session: 4.2 Community Mobilisation for Demand Generation

Session: 4.2	Community Mobilisation for Demand Generation
Learning objectives of this session	**Participants learn about:** • What is Community Mobilization? • Why it is important to engage the community? • Tools and techniques used to engage community?
Duration	1 hour
Tools	Power Point Presentation, Flipcharts, Sketch pen
Methodology	Participatory and discussion based

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of techniques of Community Mobilization. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.



Activity: 1 — 10 Minutes

The participants are divided into two teams as:

Team A having two volunteers
Team B having rest of the participants

Each team is given plenty of newspapers and to create a model with the newspapers. The participants have the liberty of using any other enhancers available with them on their selves (their personal belongings etc).

Facilitator's role:

The facilitator leads the discussion after the activity. Teams are asked to reflect on the output of each group. Following reflective questions can be posed:

- What was your experience while creating the model?
- What was better – two people or working with a larger participation?
- How did involvement happen in the larger team?
- What is the difference between the output of the two teams?
- How can the participants link this experience to mobilizing community members towards availing HIV/AIDS prevention and treatment services?

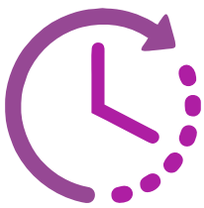
Basics of Community Mobilisation
Lecture Content for Facilitator

- Community mobilization is a capacity building process.
- Community individuals, groups or organizations plan, carry out and evaluate activities.
- Process is participatory and sustainable.
- Aim is development.
- Propelled by own initiative or stimulated by others.
- The people themselves understand the problem and its cause and are involved in articulating and responding to their own problems with the support of experts. Community mobilization encourages participation and empowerment. Through this process, community members and their resources come together to achieve a common goal.
- This is not what happens to the community – it is something that the community does.

Sources:

Advocacy and Community Mobilization for MTCT Intervention; PMTCT Training Curriculum Module 5, sourced from https://www.popcouncil.org/uploads/pdfs/horizons/pmcttc/module5.PDF

Family Planning Program Models; Community based Family Planning Toolkits; Program Design and Management ; Community Mobilization sourced from https://toolkits.knowledgesuccess.org/toolkit-topics/family-planningreproductive-health-programs-and-services



Activity: 2 — 12 Minutes

Divide participants into 3 groups, equip them with chart papers and sketch pens. Each group should be given a question to deliberate upon and write their responses. Discussion time allocated is 6 minutes and presentation time is 3 minutes per group. The questions are as follows:

- Why is it important to engage the community?
- What makes a community participate effectively?
- What makes a community resistant to participation?

Importance of Community Participation

Lecture Content for Facilitator

- Provides valuable input in identifying ways to improve intervention outcome.
- Ensures that Community members are highly motivated and invested in support of the intervention.
- Helps in identifying and addressing potential issues.
- Creates demand for interventions.
- Provides an understanding of the purpose and procedures of intervention by the community.
- Enhances mutual trust.
- Creates collective ownership.
- Contributes additional resources to the response (cost effective).
- Reaches the most vulnerable; access to services, gender equity in accessing facilities; prevents discrimination.
- Addresses the underlying issues affecting sexual and reproductive health: lack of awareness.
- Increases community ownership and sustainability.

Steps for Effective Community Mobilization

- Prepare to mobilize by broad identification of the issues for which community needs to be mobilised.
- Organize community for the first level of action, of coming together.
- Explore core issue(s) of the community and set priorities.
- Plan together with your community members.
- Act together by petitioning, meeting stakeholders and advocating with them.
- Evaluate together whether the mobilisation is effective or not, what could be further strategies.
- Celebrate achievements and give credit to work put up by every member.

The facilitator can elaborate on the tasks:

It is important to identify the issues/matter at hand of the community, in consultation with the representatives. Identifying the resources/services available within the community is also done through discussion. It is essential to have an on-going dialogue between community members thereby strengthening community organizations (committees etc.). It helps to create an environment in which individuals can empower themselves to address their own unique social, economic and health needs. Working in partnership promotes community participation. Further, identifying and supporting the creative potential, encourages communities to develop a variety of strategies and approaches. It is important to assist in linking communities with external resources. Community mobilization requires committed time to work with communities, or with a partner who works with them. The involvement of all stakeholders is crucial.

Sources:
Unit 9: Community mobilisation (practical based); Diploma in Elementary Education (D.El.Ed) sourced from https://www.nios.ac.in/media/documents/dled/Block3_507.pdf
Mobilising communities for health and Social Change; SSDI Community Mobilization Participant Training Manual; Ministry of Health, Malawi sourced from https://www.thecompassforsbc.org/sites/default/files/project_examples/community%20mobilization%20toolkits%20and%20fact%20sheet2.pdf

Activity: 3 — 12 Minutes

Divide the participants into 3 groups and discuss the various methods to mobilize community. Participants are to be given chart papers and colors. They are to sketch/draw and color possible methods of community mobilization (Facilitator to prompt the participants by giving examples of some methods– awareness building through street play, training workshop for peer educators etc).
They are asked to present the different methods identified.

Activity duration 10 minutes; presentation time 2 minutes.

Facilitator can summarise the group discussion on the following points:

- Awareness building through street play
- Leveraging on the influence of community and religious leaders effectively
- Using electronic media for dissemination of information through mobile application based counselling and knowledge assessment
- Felicitating positive role models in those who have effectively faced challenges
- Networking and advocacy with the government officials to help their schemes reach the community.
- Training workshop for peer educators
- Social Mapping to list the services available and identifying the gap

Community Mobilisation for Demand Generation of Services under NACP V

Lecture Content for Facilitator

By using the community mobilisation techniques, a Community Champion, and CBO/NGO understand the need of their community's need related to:

- HIV and STI transmission and prevention knowledge
- Risk behaviors.
- Testing and treatment needs.
- Such a CC/CBO/NGO need to work.
- To enhance community's knowledge and motivate them by various methods such as IEC, BCC and counselling to seek various services.
- Once a certain demand is created, people may seek services directly or even take help from the Community Champion and CBO/NGO.

Package of Services under NACP-V

Services	New & High Priority HRGs	Medium Priority (Maintenance)	Stable (Champions)	HRG PLHIV
Contact (FSW, MSM & TG)	3 times a month	Twice a month	Once a month	Twice a month
Contact (IDU)	4 times a month	3 times a month	2 times a month	3 times a month
Clinic Visit/RMC	Each quarter	Each quarter	Half yearly	Referral to req. health services
HIV Testing	Once in six months	Once in six months	Yearly	-
Condom & Needle Syringes	Yes	Yes	Yes	Yes
Presumptive Treatment	Yes	Need based	Need based	-
BCC	Intensive DIC & Outreach Based	DIC	Hotspot Based	At facility
Priority service for PLHIV	-	-	-	ART Initiation & Adherence, ndex Testing

NGO OST Centres

Part of IDU TI set-up. Staff largely shared with the IDU TI intervention.
OST centre located within the DIC of the IDU TI.
Medical intervention delivered by a trained part-time doctor and full-time nursing staff.
Outreach and follow-up by the outreach staff of the IDU TI.

Collaborative Public Health OST Centers

OST intervention jointly between the Government hospital and nearby IDU TI.
OST centre located in Government hospital (Medical College/District Hospital/CHC/PHC).
Separate staff at OST centre for medical and psychosocial intervention.
Outreach and follow-up by the IDU TI.

Service Package for Care, Support and Treatment

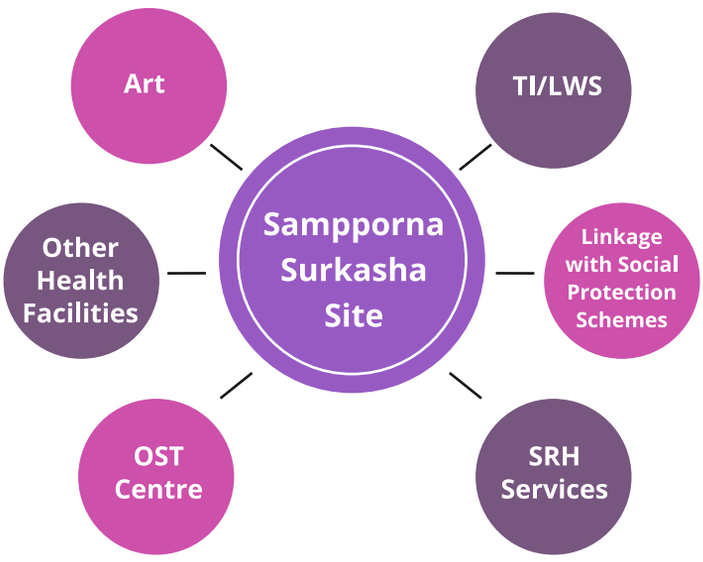
Under the NACP-V, following package for Care, Support and Treatment is being offered:

- Free Universal Access to life-long standardized Anti Retro Viral Therapy (ART).
- Free Lab Diagnostic and Monitoring services (baseline tests, CD4 testing, targeted viral load).
- Facilitating long term retention in care (Adherence on ART) .
- Prevention, Diagnosis and Management of Opportunistic Infections.
- Linkages to Care and support services and .
- Linkage to Social Protection Schemes.

Currently being introduced at 75 facilities in the first phase.

- Holistic Set of services customized as per clients' needs.
- Strong linkages and referrals with other services and social security schemes.
- Rigorous outreach and follow ups with clients.
- leveraging virtual platforms through various apps and other sources.
- The strategy will undergo mid- course correction and redressal of barriers as they are identified during implementation.

Following diagram explains the referral services under the Sampoorna Suraksha Strategy.



KP communities are required to be mobilised for first acquiring knowledge about the above stated package of services and then create demand for the uptake these services.

Source: *http://naco.gov.in/sites/default/files/Opiod%20Substitution%20Therapy%20Guideline.pdf*

WHO Good Practice Statement on Demand Creation for HIV Testing Services

- **Evidence-based platforms** for delivering demand creation include:
- peer-led demand creation interventions, including mobilization;
- digital platforms, such as short pre-recorded videos encouraging testing.
- A**pproaches that showed evidence** of increased demand include:
- advertisement of specific HTS attributes;
- brief key messages and counselling by providers (less than 15 minutes);
- messages during couples counselling that encourage testing;
- messages related to risk reduction and economic empowerment, particularly for people who inject drugs;
- motivational messages.
- Evidence suggests that the following approaches may be **less effective** for demand creation:
- personal invitation letters
- individualized content messaging;
- counselling focused on building relationship between the client and counsellor; general text messages, such as SMS

Source: *What Works For Generating Demand For HIV Testing Services, November, 2019, Policy Brief, WHO*

Reflection

Reflect on what this learning means to you and your community and how can you apply it in your context. What will you do to mobilise community and create demand for towards the service uptake.

CHAPTER - 10.0
Session: 4.3 Demand Generation on Virtual Network

Session: 4.3	Demand Generation on Virtual network
Learning objectives of this session	**Participants learn to:** • Identify Virtual Network • Devise action strategies to generate services related demand on the virtual network
Duration	45 minutes
Tools	Power Point Presentation, Case studies, Chart Papers with Pen
Methodology	Lectures, group work

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of networking, relationship management and managing community dynamics. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.

Activity: 1 — 20 Minutes

This is a simulation exercise for creating a social network.

Step 1

Tell participant to choose one group and gather one side of the training venue. Participants have to select from the following:
Group 1: Food lovers
Group 2: Film lovers
Or
Group 1: Travel lovers
Group 2: Fashion lovers

Step 2

Gather people in two groups of their choice and give them 15 minutes to interact on the given group identity. They have to interact by keeping in mind the topic given to them. Every interaction has to be on the given topic.

Step 3

After this ask them following:

- Were they able to form a network?
- How was the network functioning?
- What did they talk about?
- What information did they share?
- Did any influential person/leader emerge in the network?
- What did they do or say?

Virtual network- Concept, Operational Mechanism and Issues related to virtual network

Lecture Content for Facilitator

Social network is a network of social interactions and personal relationships which could exist in in physical spaces. However social networking is the use of internet based social media programs to make connections with friends, family, colleagues or customers. This is known as the virtual network meaning existing, seen or happening online or on a computer screen rather than in person or in the physical world.

Operational Mechanism

Before the internet access became common place, KPs interacted in physical spaces such as streets, transport hubs, brothels, markets to meet potential partners/ customers. KPs regularly experienced backlash from the police however with the advent of internet and mobile phone interactions and selection of a potential partner or customer is taking place through the virtual networks. It is now safer for KPs to operate on the virtual network and stay safer from the social and legal backlash. KPs might operate on virtual networks in the following ways:

1. By being on dating apps, sex work apps and websites.
2. By being part of whatsapp and telegram groups.
3. By being a part of Facebook and secret facebook pages.
4. By being a part of gaming apps.

Analysing Who Is On Virtual Network?

People in Focus					
Virtual Network	**FSW**	**MSM**	**TGW**	**PLHIV**	**PWID**
Facebook	✓	✓	✓	✓	✓
Secret Facebook group		✓			
Instagram	✓	✓	✓	✓	
Messenger					
SMS group					
Whatsapp	✓	✓	✓	✓	✓
Telegram				✓	
Dating apps	✓	✓	✓		
Sex work apps	✓				
Gaming apps	✓				

While the KPs may meet their potential partners and customers on virtual space they may still get referrals from another person (broker) in the virtual space. Transactions from a client and commission to the broker may also be done via on-line mechanism.

Issues related to Virtual Network

- Population size might vary on virtual network therefore making estimations difficult.
- KPs can be on Virtual Network in disguise therefore it is hard to identify them, which will create barriers in reaching them for testing and treatment.
- KPs who are a part of secret groups and private sex apps would be difficult to access by the regular HIV programs.
- KPs on these networks may be very young and not exposed to HIV awareness campaigns and prevention services hence they have unmet needs that need to be fulfilled.
- KPs on these networks need to be reached out via virtual campaigns.

Role of Community Champions and CBOs in the Virtual Network

- While Community Champions can influence on-line KPs via social media, CBOs too can do on-line outreach to reach the hidden populations.
- The role of Community Champions and CBOs would be to make social support available to a new person who made transition from virtual to physical space and link such a person to a range of health care services.
- They have to engage in demand generation activities for goods, services and support pertaining to STI/HIV prevention and treatment needs to be created among the virtual populations.

Activity: 2 **15 Minutes**

Make a KP expertise and experience-wise group of participant and then ask them to make a strategy on:

- How will they reach out to KPs on Virtual Network?
- How will they engage in demand generation activities on the Virtual Network?

CHAPTER - 11.0
Session: 4.4 Promoting PEP and PrEP in The Future

Session: 4.4	Promoting PEP and PrEP in The Future
Learning objectives of this session	**Participant learn about:** • Information on PEP and PrEP. • Will be able to disseminate this information in their community in future.
Duration	1 Hour
Tools	Power Point Presentation, Video
Methodology	Lecture and Discussions

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of networking, relationship management and managing community dynamics. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.

Activity: 1 **6 Minutes**

Facilitator to ask the participants regarding their experiences of a community member or a friend walking up to them during panic situation and report about condombreakage and what they did after that?

Post Exposure Prophylaxis (PEP)

Lecture Content for Facilitator

What is Post Exposure Prophylaxis (PEP)?

It's a medicine given to prevent HIV if a person had a possible exposure to HIV. PEP must be started within 72 hours of possible exposure to HIV. The HIV exposure could be through various means:

- If condom broke during sex.
- Needles, syringes or other equipment to inject drugs.
- Sexual assault.

PEP is for Emergency Situations

- PEP is given after a possible exposure to HIV.
- PEP is not a substitute for regular use of other HIV prevention.
- If a person is at an ongoing risk for HIV, such as through repeated exposures to HIV, such a person is an eligible candidate for PrEP (pre-exposure prophylaxis).

PEP Situation in India

PEP is recommended for occupational exposure for the health care providers. In case of sexual assault, PEP should be provided to exposed person as a part of overall package of post sexual assault care.

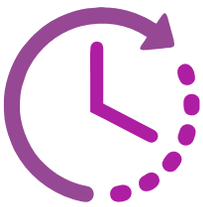
Currently some of the private health care providers do write prescription for PEP.
Availability of PEP and Its Dosage

Role of Community Champions and CBOs in providing PEP Support

Keep information regarding PEP provider ready with you. Encourage people to seek PEP support when exposed to possibly HIV within 72 hours. Develop IEC, BCC and social media campaigns to create PEP awareness.

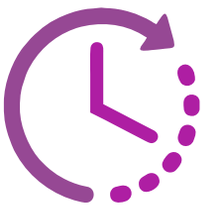
Source:
www.cdc.gov/hiv/basics/pep.html
Revised Guideline for Post Exposure Prophylaxis (PEP) for HIV- 2014, naco.gov.in

Pre Exposure Prophylaxis (PrEP)



Activity: 1 — 6 Minutes

Facilitator to ask the participants if it has ever happened that a community member or a friend walking up to them in a state of panic and reported condom breakage, whom they helped with PEP and then again such a person has sought help. When participants share their such experiences, the facilitator starts this session by saying that such a person who has repeated exposure is an ideal candidate for PrEP.



Activity: 2 — 6 Minutes

Select any of the videos for showing it to the workshop participants.

https://www.youtube.com/watch?v=wKMaEdhkyys
https://www.youtube.com/watch?v=YliTBQ0EqKU
https://www.justdial.com/photos/taal-pharmacy-nana-peth-pune-hiv-aids-counselling-services-cq2chpdhl90b445b-pc-171082689-sco-49ulpqfi69d

Lecture Content for Facilitator

What is Pre Exposure Prophylaxis (PrEP)?

- Pre-exposure prophylaxis or PrEP is the use of an antiretroviral medication to prevent the acquisition of HIV infection by uninfected persons.
- WHO recommends that people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive prevention.
- PrEP is taken orally, using an antiretroviral drug available for treatment of HIV infection (tenofovir plusemtricitabine).
- Evidence shows that, when taken consistently and correctly, PrEP reduces the chances of HIV infection to near-zero.
- PrEP is cost effective.
- PrEP does not protect against other STIs so needs to be delivered as part of a comprehensive package of HIV/STI prevention services.
- PrEP's effectiveness decreases rapidly if not taken regularly as prescribed, so addressing barriers preventing adherence is key to success.

Advantages of PrEP

- PrEP has been shown to reduce the risk of HIV infection from unprotected sex by over 90%.
- For people facing limited options to protect themselves against HIV, PrEP allows them to discreetly take control of their HIV risk.

Challenges of PrEP

- The availability of PrEP is currently limited- it is not available in public health care setting accessed by Kps.
- Low awareness level of people especially very few KPs are aware about PrEP.
- Understanding the rates at which people are able to adhere to PrEP, and addressing the barriers preventing adherence, is crucial to the long-term success of this intervention.
- Stigma and discrimination have a negative effect on uptake and adherence to PrEP.

PrEP Situation in India

Indian pharma company Cipla's generic version Truvada available in market at Rs. 2200 a month. **NACO has developed a draft national PrEP policy and guidelines**. Currently some of the private health care providers do write prescription for PrEP.

Role of Community Champions and CBOs in providing PrEP Support

- **Creating Awareness and Demand Generation:** While PrEP is available in India and is an extremely safe method of preventing HIV, its' use is neither popular nor common because many KPs are unaware about PrEP. In order to generate demand for this product KPs need to know the product, its' potential benefits, cost and availability as well as the correct guidance to use this. Unless all these conditions are met, demand for PrEP may not be generated. Community Champions and CBOs may advocate PrEP via social media communication or one-to-one interaction/ Behavior Change Communication. This information should be comprehensive, scientific, easy to search on-line and be available on multiple social media platforms and CBO websites and preferably in local languages. Also, both Community Champions and CBOs need to reach out to KP-friendly health care providers and share PrEP resources such as WHO Oral PrEP Tool kit and encourage them to prescribe PrEP to the community.

- **Encouraging PrEP adherence:** For PrEP to be effective, its adherence has to be encouraged in the same way as ART adherence. PrEP users may experience social, cultural barriers, gender-based violence and mental health challenges which may impact adherence to PrEP.

- **Enabling Environment for Acceptability:** Community Champions who are PrEP users, can consider becoming a PrEP champion. Such a person is able to create an enabling environment towards PrEP. They can also make KPs aware about correct usage of PrEP and address their concerns about the side effects.

- **Offering a Package of Services:** CBOs that are running community-based health facilities and HIV prevention services may offer PrEP as a part of their service package. CBOs can incorporate adherence as a part of their ongoing PrEP-related IEC and BCC and provide adherence counselling support for PrEP users.

- **Addressing Stigma and Discrimination:** Perceived social and self-stigma and discrimination can serve as a barrier in accessing HIV knowledge and prevention services. Community Champions and CBOs need to proactively work to promote community friendly services, sex positivity and responsible sexual behaviors such as condom and PrEP use for addressing stigma and discrimination around PrEP and HIV prevention services.

Reflections on PrEP

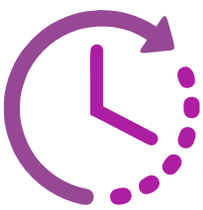
- Discuss with the participants who do they think are the ideal candidates for PrEP?
- Ask them about what role community can play in promoting PrEP in future.

CHAPTER - 12.0
Session: 4.5 HIV Self-Testing in the Future

Session: 4.5	HIV Self-testing In The Future
Learning objectives of this session	**Participants learn about:** • The point of care testing: HIV Self-Testing • Will be able to disseminate this information in their community in future.
Duration	30 Minutes
Tools	Power Point Presentation, youtube videos
Methodology	

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of networking, relationship management and managing community dynamics. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.



Activity: 1 — 3-7 Minutes

Select any of the videos for showing it to the workshop participants.

https://www.youtube.com/watch?v=VhelTAWTYko
https://www.sahayindia.org
https://www.orasure.com/products-infectious/OraQuick-Self-Test.html
https://www.insti.com/hiv-self-test/
https://www.youtube.com/watch?v=hg7hPr5W5pk (7 minutes)

Set the context for this HIV ST by asking following questions:

- **What did they think about the HIV ST?**
- **Who are for and who are against? Give their reasons?**

Lecture Content for Facilitator

The College of American Pathologists (CAP) defines point-of-care testing (POCT) as **testing that does not require dedicated, permanent equipment space.** That is, tests are performed with devices brought to the bedside or other patient locations such as the operating room (OR). HIV Self Test (HIV ST) is a POCT which is conducted by a person either assisted or unassisted by taking oral fluid (saliva) or blood. This is a screening test and a further confirmatory test is required to verify the positive screening results. Key evidence has shown that HIV ST is safe and accurate, highly acceptable, facilitates access, up take and frequency of testing among those at high risk and who may not test otherwise. Evidence points out that it has a comparable linkage, empowers users, is affordable and cost-effective when focused. Therefore, WHO recommends that HIV Self-Testing should be offered an approach to HIV testing services.

Why move to HIV ST as a POCT?

- To generate rapid results.
- To enable clinician to recommend a further course of action which will help better client outcomes.
- To recommend therapeutic interventions.
- HIV Test is the first step of treatment care cascade. If people undergoing HIV tests receive results faster without having to travel back for the results, the outcomes related to treatment cascade would be better.

Where can HIV ST reach?

HIV ST is an easy to use POCT- it can be used in a small private space practically anywhere- homes, brothels, community centers, health clinics and even social venues such as parties and spas.

WHO Pre-Qualified HIV ST Products

Oral fluid based

Oraquick→ HIV Self Test

Blood based

Mylan/Viatris HIV Self Test

Autotest VIH→

SURE CHECK→ HIV Self Test

INSTI→ HIV Self Test

Situation in India

A qualitative study supported by NACO and led by the International AIDS Vaccine Initiative, New Delhi, Tata Institute of Social Sciences, the Humsafar Trust and YRG Care, in the year 2018 evaluated the acceptability and feasibility of HIV ST among key populations in India. This study, which later became the technical brief of NACO, found that HIV ST was highly acceptable to KPs, particularly for those populations that are hard-to-reach (internet based, mobile population). Integrating counselling and linkage to care for those availing HIV ST as well as creating awareness and education with an emphasis on HIV ST as screening test was essential.

In the year 2021 PATH-Humsafar Trust- SAATHI consortium and partners have embarked on a HIV ST demonstration study across the five different models which are the community-based model and private clinic-based model, community pharmacy model, workplace model and virtual model. The HIVST project is getting implemented in the 13 states with the highest HIV prevalence. The states are Andhra Pradesh, Delhi, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Nagaland, Punjab, Tamil Nadu, Telangana, West Bengal and Uttar Pradesh. The project is using imported HIVST kits namely. This study will provide important inputs into HIV ST related policy decisions. Currently, India is yet to have a WHO pre-qualified indigenous HIV ST.

Future Role of Community Champions and CBO/NGO in Promoting HIV ST

At the moment India does not have HIV Self-Test kit as a part of the service package.If in near future HIV Self-Test kit is available then it will be along with a policy guidance from NACO. Community Champions and CBO/NGO will have to promote HIV ST by following NACO policy guidance. They will also have to ensure that HIV ST screened person is linked to confirmatory testing facility and is linked to care.

Source:
https://unitaid.org/assets/Unitaids-WHO-HIVST-landscape-report-2020pdf
Community Perspectives on making HIV Self-Testing accessible as a comprehensive prevention package naco.gov.in/sites/default/files/Technical%20Brief%
20on%HIV%20 Self%20testing.pdf

Annexure

Revamped and revised elements of Targeted Interventions for HIV Prevention and Care Continuum among Core Population: Strategy Document NACO, 2021

New HRG	High Priority	Medium Priority	Stable HRGs	HRG PLHIV
Outreach				
Contact four times in a month	Contact three times in a month	Contact twice a month	Contact once a month	Contact based on need and priority for linking with ART and tracking LFU
• Focus on rapport building, risk assessment, and providing all ssential services • Equip the HRGs with knowledge and skills on STI/HIV prevention in a step-by-step approach • Counsel for behaviour change	• Focus on risk reduction and increasing service uptake • DIC-based intensive IPC/ Counselling and follow-up outreach • Greater engagement of ORW for intervention • Risk reduction counselling	• Focus on retaining HRGs for existing services • Outreach-based IPC • Risk reduction counselling • Condom / Needle Syringe demand analysis and supply	• Focus on keeping HRGs negative and motivate HRGs for sustained behaviour change • Engage the community but with a lesser intensity • Form a champions group and engage them in intervention activities • Train members of community committees as motivational speakers/role model for behaviour change	• Navigation to ART centre for ART initiation • Adherence support as well as step–up adherence counselling as per the need • Priority for LFU tracking • Mobilising for CD4 and VL testing
Services				
Condom / Needle Syringe demand analysis and supply	Condom / Needle Syringe demand analysis and supply		Exploring new models of condom distribution / encouraging social marketing, if the community prefers Establish new outlets / identify one champion as a volunteer for the secondary distribution of condoms, lubes and N/S as appropriate for the sub pop	Stock condom/ needle syringe at DIC Positive health dignity and prevention (PHDP)

New HRG	High Priority	Medium Priority	Stable HRGs	HRG PLHIV
• OST Counselling and navigation to OST centre for enrollment, link to support groups	• OST Counselling and navigation to OST centre for enrollment, link to support groups • Flexible timing at OST centres based on IDUs convenience	• Flexible timing at OST centres based on IDUs convenience	• OST Clients, provide retention counselling and follow up by OST centre staff on weekly basis If low priority IDUs (on OST) miss a dose for 3 days or more an immediate home visit / follow up by OST counsellor nurse be conducted.	• Retention OST counselling to IDU PLHIVs Navigate IDU PLHIV on OST to ART Centre for ART initiation.
• Presumptive Treatment	• Quarterly PMC • Camp-based approach for STI in prioritized hotspots/ populations	• Quarterly RMC	• Encourage the HRGs to avail services in a self-initiated way. • 6 monthly RMC and need-based STI services.	• Need-based referral to health service incl. STI services Linking with social protection schemes • Other prevention services as per the guideline
• HIV Testing: Immediately after registration and within a month	• HIV Testing: Once in six (6) months • Community-based screening in prioritized hotspots/ populations	• HIV Testing: Once in six (6) months	• HIV Testing: Once a year	
• Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	• Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	• Use network models for reaching sexual, injecting and social networks of HRGs and their sexual artners and spouses	• Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	• Conduct index testing
				• Navigation of HIV-positive HIRG for ART initiation.
• Referral for other health services and social protection schemes	• Referral for other health services and social protection schemes	• Referral for other health services and social protection schemes	• Referral for other health services and social protection schemes	• CD4 Test: Once in six months VL Test: Annually

Reference: *Opioid Substitution Therapy Under National AIDS Control Programme*

Source: *http://naco.gov.in/sites/default/files/Opiod%20Substitution%20Therapy%20Guideline.pdf*

DEFINITION OF 'INJECTING DRUG USER' or PWID

Different definitions have been used for identifying who is an IDU. Some researchers opine that a person who has injected even once in his/her lifetime is an IDU, while others define an IDU as someone who has injected atleast once in the past 12 months. In India, for programmatic purposes, **DAC defines an IDU as a person 'who has used any psychoactive substance through injecting route for non-medical purpose at least once in the last three months'.** This definition is based upon the recommendation of experts working in the field of IDU in India.

Under the National AIDS Control Programme, the term 'Opioid Substitution Therapy' (OST) is currently in use.

OST is a process in which opioid-dependent injecting drug users are provided with long acting opioid agonist medications for a long period of time under medical supervision along with psycho-social interventions. Short term treatment of opioid dependence lasting for a couple of weeks called 'detoxification' which involves management of acute withdrawals alone, is associated with very high rates of relapse. Long term treatment is hence necessary for opioid dependence. OST is one such long-term treatment option.

The **opioid medicines usedfor OSTrelieve drug-related withdrawals and cravingand do not lead(when used in appropriate doses) to acute intoxication** (which is seen with use of illicit opioids). Thus, the client is maintained in a state which produces neither intoxication nor withdrawals,nor craving. Due to this, the client does not need to use opioids to produce relief of withdrawals or craving.

Ascomparedtotheillicitopioidsthatactquicklyandforashortperiodoftime,**opioidmedicines used for OST act slowly and for a long period of time (for at least 24 hours).** As a result, the client does not have to spend time on procuring or using opioids frequently in a given day and can focus on other important activities like occupational and family responsibilities.

The illicit opioids used by the clients are taken by routes that are potentially harmful. Many harmful effects faced by IDUs are due to the injecting route of administration. **On the other hand, opioid medicines used for OST are administrated orally or sublingually, which is a much safer route.** This saves the client from incurring harmful effects of opioid use.

As the IDUs procure the opioids mostly through illegal channels, they are often not aware of the purity of the opioid product they inject. This is especially true for heroin and its impure form, smack. The purity of street heroin varies across different time periods as well as across the drug suppliers. This may result in life-threatening overdose situations if the heroin is purer than usual. On the other hand, the **potency and purity of opioid medicines used for OST is known;** this helps in averting overdose situations.

As the street opioid drugs are costly, IDUs often resort to illegal activities to finance their drug use. However, as the opioid medicines used for OST are available in government supported centres/ hospitals free of cost, the client does not have to resort to illegal means. This helps in reducing legal complications faced by the clients and also reduces instances of petty crimes like thefts, etc. in the society.

During the illicit drug use phase, IDUs are often branded as anti-social or criminal by the families and the society. When on OST, such IDUs are seen as sufferers and 'patients'. This renewed status helps the clients to seek help for other problems as well and makes them amenable for other help that can be provided.

BENEFITS OF OPIOID SUBSTITUTION THERAPY

- Reduction in injecting behaviour
- Improved adherence for other treatment, especially treatment for HIV, tuberculosis and viral hepatitis
- Reduction in opioid use
- Reduced overdose related deaths y Reduction in criminality
- Reduction in domestic violence
- Improved child care and family ties y Improved productivity

STATUS OF OPIOID SUBSTITUTION THERAPY IN INDIA

NGO OST CENTRES

- Part of IDU TI set-up. Staff largely shared with the IDU TI intervention
- OST centre located within the DIC of the IDU TI
- Medical intervention delivered by a trained part-time doctor and full-time nursing staff

Outreach and follow-up by the outreach staff of the IDU TI

COLLABORATIVE PUBLIC HEALTH OST CENTRES

- OST intervention jointly between the Government hospital and nearby IDU TI
- OST centre located in Government hospital (Medical College/District Hospital/CHC/PHC)
- Separate staff at OST centre for medical and psychosocial intervention
- Outreach and follow-up by the IDU TI.

Add references or any annexure if required here

Notes

Notes

Notes

Notes

Supported By:
Hindustan Latex Family Planning Promotional Trust
B-14A, Iind Floor, Sector-62, Gautam Budh Nagar, Noida,
Uttar Pradesh - 201307
Contact: 120 - 4673600, Email: info@hlfppt.org